

Apple Health Dental Program

Options for Improving Access

Engrossed Substitute House Bill 1109; Section 211 (52); Chapter 415; Laws of 2019

November 15, 2019



Apple Health Dental Program



Medicaid Program Operations &
Integrity

P.O. Box 45502

Olympia, WA 98504

Phone: 360-725-1226

<http://hca.wa.gov>

Clinical Quality and Care
Transformation

P.O. Box 45502

Olympia, WA 98504

Phone: 360-725-9967

<http://hca.wa.gov>



Table of Contents

- Executive summary 2
- Background..... 3
 - Improving access and outcomes 4
- Access strategies in other states..... 7
 - Dental Champions..... 7
 - Strong public health and dental provider partnerships 8
 - Dental school partnerships..... 8
 - Reduce administrative burdens for providers 8
 - Using mid-level providers 8
 - Consider mobile and tele-dentistry..... 9
 - Dental homes 10
- Costs associated with increased access and utilization..... 10
- Service delivery models 11
 - Fee For Service..... 11
 - Administrative Service Organization or Third Party Administrators..... 12
 - Carved-Out Managed Care 12
 - Carved-In Managed Care..... 13
 - Administrative Costs 14
- Conclusion 15
- Appendix A: Medicaid Dental Program Models and Success Factors 17



Executive summary

Engrossed Substitute House Bill 1109 (2019) Section 211 (52) directed the Washington State Health Care Authority to continue providing Medicaid dental services “*through fee-for-service and may not proceed with either a carved-out or carved-in managed care dental option. Any contracts that have been procured or that are in the process of being procured shall not be entered into or implement. By November 15, 2019, the authority shall report to the governor and appropriate committees of the legislature a plan to improve access to dental services for Medicaid clients. This plan should address options for carve-in, carve-out, fee-for-service, and other models that would improve access and outcomes for adults and children. The plan should also include the cost for any options provided.*”

The Health Care Authority researched Medicaid dental programs across that nation evaluating programs by the type of service model, benefit packages, costs, populations served, access, and utilization performance. After careful examination, it is clear that attempting to address the issues of access and outcomes by simply changing service delivery models will not necessarily lead to the desired change without making other alterations. There seems to be a consensus that Washington Apple Health (Medicaid) patients could benefit from broader access to a system that is not only affordable and accessible for patients, but also inviting for dental providers to participate.

This report outlines the benefits and risks associated with administering dental benefits using the following service models: (i) carved-in; (ii) carved-out; (iii) fee-for-service; and (iv) other service delivery models. We also provide examples of how these models, coupled with other policy changes, could improve the system.

One such policy change is increasing provider rates. The Apple Health dental program’s reimbursement rates for adult dental services have not changed since 2007. Nationally Medicaid reimbursement rates are 46.1% of commercial fees; Washington’s rates are 32.4%.¹ An increase in rates, even a modest one, would draw additional dental providers to the Apple Health dental program and allow us to remain competitive within the marketplace. Other states that have increased reimbursement rates have seen improvement with client access and dental outcomes. These states, while having their own unique Medicaid populations and policies, serve as models for Washington to emulate in our own dental program.

Increasing access and driving utilization to better serve Washington residents will increase the costs associated with the Apple Health dental program. It is anticipated that a 5 percent increase in adult utilization, coupled with a 10 percent increase in provider reimbursement rates, would increase the budget by \$11.4M, which is consistent with the previous Governor’s budget estimate.

¹ (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Background

Washington's Apple Health dental program provides a comprehensive benefit package including diagnostic, preventative, and restorative services. While most Apple Health benefits are administered through a managed care delivery service model, Apple Health dental benefits remain Fee-For-Service.²

The Apple Health dental program expenditures have grown from \$220.3 million in 2011 to \$387 million in fiscal year 2018. This is due, in part, to changes in the adult benefit package and an expansion of Washington's Medicaid population. In 2011, adult dental benefits were reduced from a comprehensive benefit to emergency dental service coverage only. In 2014, adult comprehensive benefits were restored, and the number of Washingtonians eligible for Apple Health benefits increased with the Affordable Care Act's Medicaid expansion provision.

While the Apple Health dental reimbursement rates for adults has not changed since 2007, the program has been able to provide enhanced rates for children aged 0 through 5 participating in the Access to Baby and Child Dentistry (ABCD) program. The ABCD program, a public private partnership with the Arcora Foundation, addresses oral health for Apple Health eligible children aged 0 through 5 by connecting these children with dental care and providing participating dentists with enhanced reimbursement payments.

Initiated in 1995, ABCD focuses on expanding children's access to dental services in Washington State by providing preventative and restorative dental care to Apple Health's eligible children, with the emphasis on connecting these children with care by the time they are one year old. It is based on the premise that starting dental visits early will yield positive behaviors by both parents and children, thereby helping reduce the development of dental cavities and the need for costly restorative work in the future. This concerted effort to increase access with this age group has yielded impressive results. In fiscal year 2017 56 percent of children enrolled in Apple Health accessed dental care compared to 45 percent in fiscal year 2008.

Other steps taken to improve access to dental services through Apple Health over the last two years include:

- Prior Authorizations:
 - Several high volume procedures were removed from the prior authorization list resulting in streamlined client visits while lowering administrative burden to providers.
 - Improvements to the prior authorization process reduced the processing time to less than the 15 day requirement.
- Added tele-dentistry as a billable procedure with the intent of creating more access for rural clients.

The first two changes improved the prior authorization process by reducing the administrative workload shouldered by dental providers. The addition of a billable procedure for tele-dentistry

² (Health Care Authority, 2019)

was a direct attempt by the dental program to improve access, especially for Apple Health clients who reside in the rural areas of Washington.

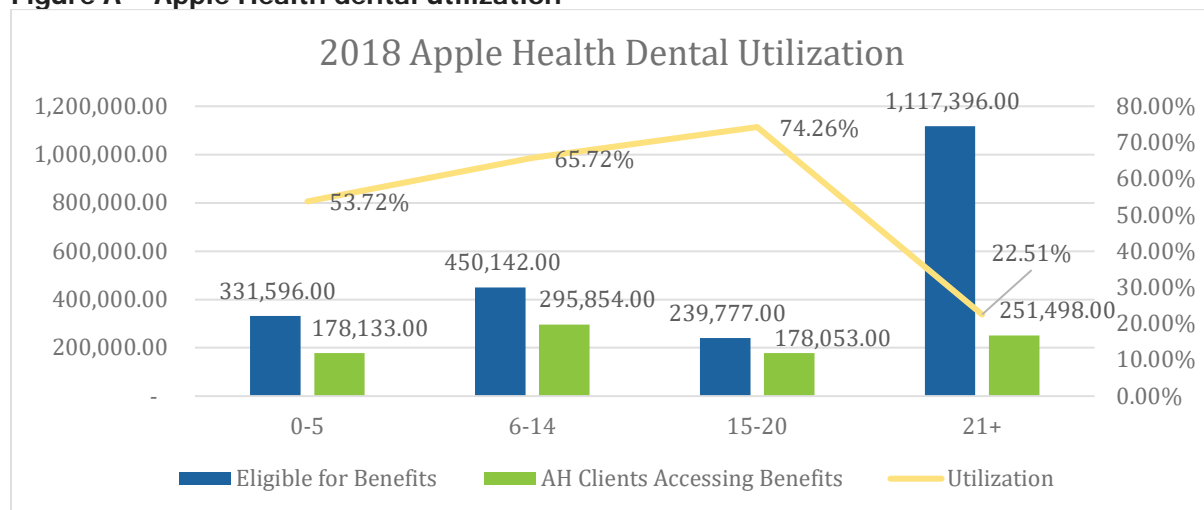
Improving access and outcomes

HCA’s efforts to improve dental access and increase utilization have been more successful for children than adults. In order to discuss access it is important to understand HCA’s methodologies to measures access. Unlike managed care benefit programs, where CMS provides time and distance guidelines to ensure clients have access to health care, there is no clear methodology to measure access in a Fee For Service (FFS) program. There are a number of ways to measure access - including utilization, the number of clients accessing services, the number of providers enrolled, or the number of providers billing the program for services rendered.

A look at HCA’s 2018 data, shown in Figure A, shows that the Apple Health dental program’s utilization numbers are above 50 percent with all groups aged 0-20, and is 22 percent for Apple Health clients aged 21 or older. Utilization among Washington children aged 0-5 was 51 percent in 2016, 18 percent above the national average of 33 percent. A look at CMS’ 2018 utilization data reveals that 56 percent of Washington children aged 0-20 received one preventative care visit during federal fiscal year 2018, outperforming the national average of 52 percent.³

Clearly, the focus of the ABCD program has proved successful for children, but the adult utilization is lagging. Adult utilization lags behind pediatric utilization in all payer populations, but finding the right Adult utilization benchmarks is difficult the only national data available is from 2013, when Apple Health dental benefits were limited to emergency services. Using 2013 data, the average utilization across 21 states with a limited or comprehensive adult benefit was 22 percent.⁴ Assuming the national average remains close to the same, Washington’s 23 percent utilization rate is above average.

Figure A – Apple Health dental utilization



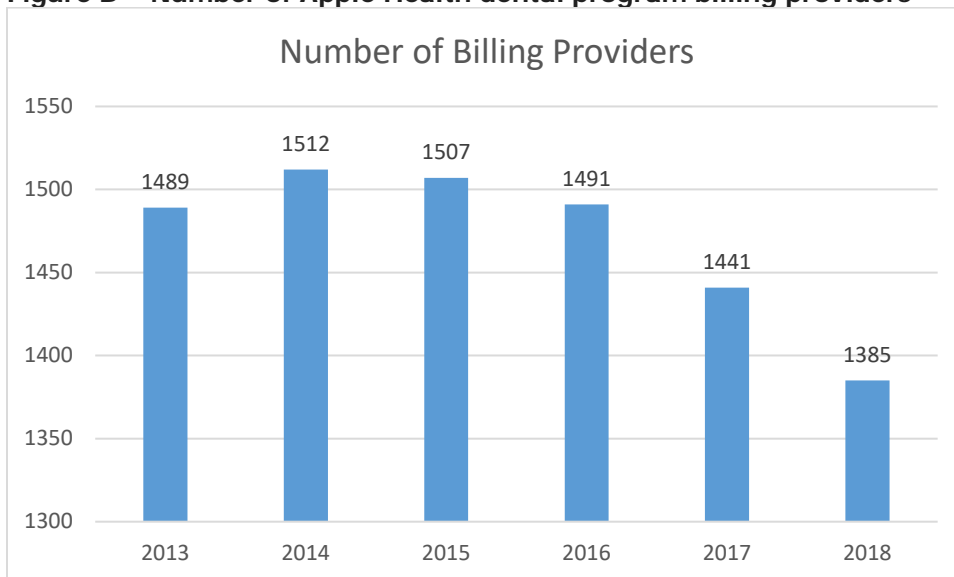
³ (Center for Medicare & Medicaid, 2018)

⁴ (Centers for Medicare & Medicaid Services)

Improving access and driving utilization is a complex question. The success of the ABCD has been, in part, the effort to connect Apple Health clients with dental providers. This connection is made possible by a network of ABCD dental champions and county coordinators who work directly with the dental providers in their area to educate and enroll them as participants in the program.

The ABCD program’s provider engagement activities have proved successful for the children enrolled in Washington’s Medicaid program, but there are very few efforts focused on the Apple Health adult population. “In 2015, Washington had only 19 percent dentist participation in Medicaid or CHIP for child dental services, compared with 38 percent nationally.” (Fontana, Gerstorff, Lewis, & Saypoff, 2020) An examination of the HCA’s data reveals that while there are 3,738 enrolled providers, only 1,385 providers billed for services in 2018. In fact, the number of providers billing for Apple Health services has dropped steadily since 2014.

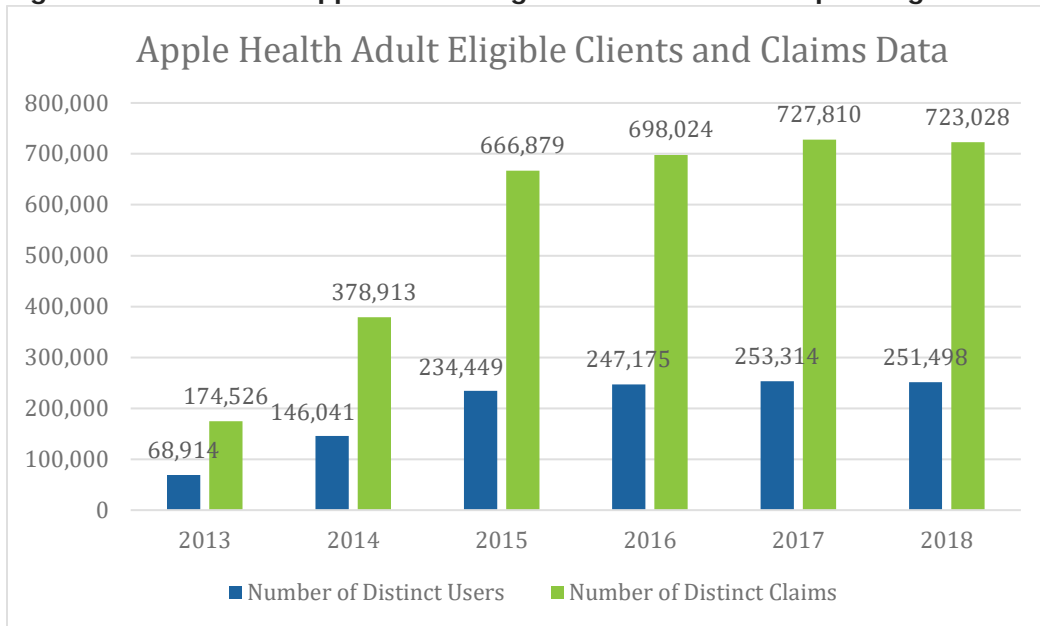
Figure B – Number of Apple Health dental program billing providers



While the number of dental providers participating in the Apple Health dental program has dropped since 2014, the number of Washingtonians eligible for Apple Health has increased. Utilization percentages for the Apple Health program’s adult population have not grown significantly, but the number of clients receiving services has increased, see Figure C.



Figure C – Number of Apple Health eligible adults and corresponding dental claims data



Fully understanding why the Apple Health provider network was able to absorb additional patients requires a comprehensive study, but there are two known contributing factors. One is the use of non-traditional providers, the other is the participation of Federally Qualified Health Centers (FQHCs).

Non-traditional providers are qualified health care practitioners that are neither a state licensed dentist or under the supervision of a dentist. “According to the 2017 CMS-416 data set, 7.25 percent of Medicaid enrolled children in Washington received oral health services from non-dental providers, compared with the national average of 4.59 percent.” (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

FQHCs serve an important role in the current dental program by providing Apple Health clients access to dental services. These centers are community-based providers who offer a variety of services, regardless of a patient’s ability to pay. These clinics receive an encounter based enhancement fee that is paid using a prospective payment system (PPS). These “PPS encounter rates are calculated annually by the state based on provider cost reports and are intended to cover the clinic’s operating cost. (Fontana, Gerstorff, Lewis, & Saypoff, 2020) In fiscal year, 2017 the total cost of the Apple Health dental benefit was approximately \$358.8 million, encounter based FQHC payments make up 35 percent of the total cost or \$125 million.

Figures B and C highlight that while Washington’s dental provider participation rate is low, FQHCs and private providers who are participating have increased services since Medicaid expansion. At the same time, the data emphasizes the need to increase provider participation in the Apple Health program. In preparation for this report HCA asked Washington dental providers, those serving Medicaid clients and those who do not, to identify changes that would encourage them to either participate in Medicaid or increase their current participation levels. Washington providers rated the following areas for improvement in order of importance: provider reimbursement rates,



support with missed appointments, simplified prior authorization processes, benefit package, and transparency with the regulatory authority's audit process.

The Apple Health dental program has made some changes to address those concerns, like simplifying the prior authorization process. It is not as easy to address provider reimbursement rates and provide support with missed appointments.

Outside of initiatives like the ABCD program, provider reimbursement rates have not changed since 2007. "According to a study by the American Dental Association Health Policy Institute, 2016 nationwide average FFS reimbursement rates for Medicaid child dental services were approximately 61.8 percent of the reimbursement rates for commercially insured children. The comparable number for Washington was 40.4 percent below the average. For adult dental services, Medicaid fees are 46.1 percent of commercial fees nationally, and 32.4 percent in Washington." (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Increasing rates, as cited by Washington's dental providers, is just one component to achieving increased access and driving higher utilization rates. HCA's research of other state's Medicaid dental programs reinforces this assertion. States that have seen success have addressed provider reimbursement rates in conjunction with other strategies. For example, the use of a "Dental Champion," leveraging non-dental health care providers to augment preventative care efforts, partnering with dental schools, alternative treatment sites, and utilizing non-traditional dental professionals have all proven effective in other states.⁵

Access strategies in other states

Aside from identifying a preferred service delivery model, many other strategies can be employed to increase access, drive utilization and improve outcomes among Apple Health clients. Options like leveraging contracts with the state's public health offices to perform outreach activities and connect Apple Health eligible clients with dental providers could help alleviate Washington's dental provider concerns regarding missed appointments. Utilizing the expertise of a dental ASO or managed care organization could help the Apple Health dental program to strengthen its network and actively engage providers. The following explores strategies that other states have employed:

Dental Champions

Connecticut, Maryland, Virginia, and Rhode Island have employed the use of dental champions to assist their state's Medicaid agency in their efforts to build robust and engaged provider networks. In Connecticut, the state's Dental Director led the way to build relationships with the provider community and stakeholders to increase access. In Maryland, the Secretary of the Department of Health and Social Services championed an effort to recruit more providers to serve the state's Medicaid eligible children. In the Commonwealth of Virginia, a former Medicaid Director worked directly with Virginia's Dental Association to increase access.⁶ The ability of the Medicaid agency to utilize a dental champion to create and maintain relationships with the state's dental providers can

⁵ ADA Access to Oral Health Care

⁶ ADA Access to Oral Health Care

occur regardless of the service delivery model employed to deliver dental benefits. Connecticut, Maryland, and Virginia all employ an ASO service delivery model while Rhode Island's dental program utilizes a carved-out managed care model.

Strong public health and dental provider partnerships

In Nebraska, Maryland, and North Carolina a partnership between public health departments and the state Medicaid agency has also produced results. Public health nurses, employed by the local health departments, contract with the state's Medicaid program to perform outreach activities across the state. The nurses are responsible for reaching out to families to inform them of their benefits, providing education and helping them connect with local dental providers. In addition, these nurses provide support to providers by following up with patients who do not show up for scheduled appointments, a primary concern amongst health care providers.⁷ Again, this unique approach is achievable regardless of the dental program's service delivery model. As noted above Maryland's dental program is administered by an ASO, Nebraska's dental benefit is delivered via a carved-out managed care model, and North Carolina is a Fee For Service state.

Dental school partnerships

Collaborating with dental schools is another way of increasing access. State Medicaid programs across the country have worked directly with their state's dental schools to provide dental clinics in rural underserved areas. Alabama, Maryland, Nebraska, North Carolina and Texas have all worked to create loan repayment programs for newly graduated dentists who agree to practice in rural areas.⁸

Reduce administrative burdens for providers

Maryland, Virginia and Connecticut all cite efforts to reduce administrative burdens as key in their ability to increase access. Providing a single point of contact for providers, reducing the number of procedures that require prior authorization and even assisting providers to fill out their Medicaid provider agreements were just some of the ways to achieve a more simplified administrative process for providers. In theory, a single point of contact is easily achieved by retaining a Fee For Service program, but while this is Virginia's Medicaid dental service delivery model, Maryland and Connecticut both achieve the single point of contact in partnership with an ASO or Third Party Administrator (TPA). (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Using mid-level providers

Utilizing non-traditional providers, specifically Dental Health Aide Therapists (DHATS) has proved successful in Alaska's Fee For Service Medicaid dental program and Minnesota's carved-in managed care dental program. A dental therapist is a mid-level provider who practices a limited number of dental procedures. Under the supervision of a licensed dentist, a DHAT may perform fillings and

⁷ (Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports, 2011)

⁸ (Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports, 2011)

simple extractions. Evaluations have shown that dental therapists are not only competent, but also comparable to dentists when completing basic restorations.⁹

In 2009, Minnesota's became the first state to authorize dental therapist and advanced dental therapist models. Created to serve low-income and underserved populations, dental therapists have made significant impacts since its inception. Clinics employing dental therapists are reporting cost savings. Medicaid reimbursement does not distinguish which type of provider renders treatment; with dental therapists' wages being lower than that of a dentist, more patients are being treated. By treating more of these clients, dental therapists are decreasing long wait times and travel times, and increasing access.

While dental therapists provide a new strategy to address access, dental hygienists have been recognized as an integral part of the dental community for years. ¹⁰States like Oregon, Vermont, Maine, Minnesota, Colorado, and New Mexico have taken steps to increase the scope of practice for dental hygienists. This expanded dental hygienist scope allows this provider type to plan treatments, supervise dental assistants, and diagnose decreases the overall costs of preventative and restorative care.¹¹ Again, this approach has increased access in states with varied service delivery models, Vermont, New Mexico, and Minnesota's carved-in managed care model, Colorado's ASO partnership, and Maine's Fee For Service program.

Consider mobile and tele-dentistry

Mobile dentistry provides another option for consideration. Through mobile dental vans or portable dental clinics, providers are able to travel out to rural areas, schools, and nursing facilities to serve those who would not have been able to receive dental treatment. Fifteen services may include an examination, sealants, a dental cleaning, and fluoride. Children, living in rural areas with little to no dental insurance, are at a higher risk for cavities and poor oral health. However, mobile clinics may reduce that risk; for those who visited the mobile dental clinic more frequently, those clients saw lower rates of cavities.¹²

Similar to mobile dentistry, tele dentistry is a way of utilizing technology to deliver oral healthcare from a provider in one location, to a patient in a physically different location. By using electronic health records, digital radiographs, and the Internet, dental providers can help those who are unable to access care. States like California, Colorado, and Missouri, have used tele dentistry to create virtual dental homes.¹³ Tele dentistry exists within the Apple Health dental network, but there is an opportunity to incentivize this type of alternative practice setting. These virtual dental homes deploy dental hygienists to community sites to provide services and collect records. These records are digitally transmitted to a dentist to review for possible treatment or referral.

⁹ (Minjarez & Roberts, 2017)

¹⁰ (Office of the Revisor of Statutes, n.d.)

¹¹ (Garfield, Hinton, Cornachione, & Hall, 2018)

¹² (White Paper Teledentistry: How Technology Can Facilitate Access to Care, 2019)

¹³ (Increasing Access to Care through Teledentistry: A NNOHA Promising Practice)

Researchers in California found that 66 percent of the clients in the virtual dental homes only needed preventive services and did not require a physical visit to the dentist.¹⁴

Dental homes

While mobile and tele dentistry are innovative techniques to bring the dentist to his or her patients, providing a dental home for Medicaid clients is another way of ensuring both access and promoting utilization. Dental homes establish a “relationship between the dentist and patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.”¹⁵ A 2016 report from the Office of the Inspector General found that connecting a Medicaid eligible child to a dentist increased the likelihood that the child would receive the preventative care on a regular basis.¹⁶ Providing a dental home to all eligible Medicaid clients is a large undertaking, but an iterative implementation approach has proven successful in Maryland. Maryland implemented its dental home initiative county by county and over the course of five years was able to secure a dental home for all Medicaid eligible children.¹⁷

Costs associated with increased access and utilization

Increasing access and driving utilization will increase the costs associated with the Apple Health dental program. Milliman’s report “Medicaid Dental Program Models and Success Factors,” in Appendix A, explores the costs associated with increased access and utilization numbers. This examination utilizes baseline cost estimates from calendar year 2017 and “reflect total benefit costs regardless of federal or state funding source.” (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

The report illustrates the following Fee For Service costs for the adult population based on four scenarios:

- Costs based on a 5 percent increase in adult utilization.
- Costs based on a 5 percent increase in adult utilization and a 10 percent increase in reimbursement rates.
- Costs based on a 5 percent increase in adult utilization, a 10 percent increase in reimbursement rates, with FQHC supplemental payments.
- Costs associated with increasing the adult fee schedule to match the current child fee schedule levels.

While all of these scenarios provide valuable information, a look at the costs associated with a 5 percent increase in adult utilization coupled with a 10 percent increase in provider payments and payments to FQHCs, seems to be reasonable as this report has already established the need to increase adult reimbursement rates and the large role FQHCs play in providing dental services to

¹⁴ (White Paper Teledentistry: How Technology Can Facilitate Access to Care, 2019)

¹⁵ (Definition of Dental Home, 2018)

¹⁶ (Murrin, 2016)

¹⁷ (The Impact of Medicaid Reform on Children's Dental Care Utilization in Connecticut, Maryland, and Texas, 2014)

Washingtonians. “This scenario results in a budget impact of 3.2 percent as shown in the table below.” (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Table 1 – Budget impacts of Apple Health dental program benefits

BENEFIT COST TYPE	BASELINE (\$MILLIONS)	SCÉNARIO 3 (\$MILLIONS)	\$\$ CHANGE	% CHANGE
Adult Dental Benefit Cost	\$ 51.7	\$ 59.7	\$ 8.0	15.5%
Child Dental Benefit Cost	\$ 182.0	\$ 182.0	\$ 0.0	0.0%
TOTAL BENEFIT SERVICE COST	\$ 233.7	\$ 241.7	\$ 8.0	3.4%
Adult FQHC Supplemental Payments	\$ 70.3	\$ 73.8	\$ 3.5	5.0%
Child FQHC Supplemental Payments	\$ 54.7	\$ 54.7	\$ 0.0	0.0%
TOTAL FQHC SUPPLEMENTAL COST	\$ 125.0	\$ 128.5	\$ 3.5	2.8%
TOTAL DENTAL BENEFIT COST	\$ 358.8	\$ 370.2	\$ 11.4	3.2%

Using the same baseline costs above, Milliman also tested the “unit cost impact of setting Washington’s 2017 Medicaid adult dental fee schedule equal to the child fees. If providers were to be reimbursed at the 2017 child fee schedule for adult dental services, the average unit cost of adult services would increase by 28 percent, which, prior to any assumed increase in utilization and assuming FQHCs continue to be paid according at the same PPS rates, would increase the estimated Medicaid dental benefit cost by 2.5 percent. Adding in the impact of an assumed adult utilization change of 5 percent, and then additionally the assumption that FQHCs would also receive the enhanced payment rate beyond PPS, would affect Medicaid dental benefits costs by 4.3 percent and 5.9 percent respectively.” (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Service delivery models

Fee For Service

In a Fee For Service delivery model, HCA, like any state employing this model, designs, implements, and is solely responsible for all aspects of the program: rate setting, credentialing providers, maintaining provider networks, paying claims, benefit packages, provider and client customer services, prior authorization.

The state sets the provider’s reimbursement rates, pays claims, and tracks Federally Qualified Health Care Center (FQHC) encounters per the federal requirement. As the only entity involved in the dental program tracking and identifying where Medicaid dollars are spent is easily identifiable.

Inherently, the Fee For Service model lends itself to administrative simplification as the state retains full control of the program and making changes to the process requires making changes to only one organization. Providers cite prior authorization processing and maintaining provider credentialing as two areas that cause undue hardship on their practices.¹⁸ Like HCA’s efforts to reduce administrative burdens discussed above, there are levels of administrative burden that providers identify as barriers. This leaves the state agency responsible for finding innovative ways

¹⁸ (Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports, 2011)

to reduce these burdens whereas a third party may have more experience identifying the root cause and implementing a solution.

There are some potential drawbacks to this autonomy, as the party responsible for setting reimbursement rates, states appear to be less prepared to introduce value based payment models, patient and provider engagement and care coordination methodologies. Specialized vendors, like a dental ASO or Managed Care Organization, have more experience with alternative payment models and some employ care coordination and patient engagement tools. Integrating the Apple Health dental benefit with the physical and behavioral health benefits proves more difficult because two of the three benefits are primarily delivered in a managed care model.

Administrative Service Organization or Third Party Administrators

The option to contract with an Administrative Service Organization (ASO) or Third Party Administrator (TPA) allows the dental program to remain Fee For Service, but provides the state a partner who is tasked with certain areas of the program's administration. The most common partnership arrangements task the ASO/TPA to process claims and prior authorizations, build and maintain the provider network, and oversee communication with clients and providers.

The terms of the state's contract plays a key role not just in the duties assigned to the ASO/TPA, but also allows the state to assign strategies, like collaborating with local health care authorities to provide care coordination for Medicaid clients, to its contractor who may have more experience and the resources to manage this type of relationship.

A dental ASO/TPA would also have experience leveraging strategies aimed at administrative simplification for providers as well as building and maintaining an engaged provider network. Improvement efforts can be outline in the ASO/TPA contract allowing the state to benefit from the ASO/TPA's experience without having to expend state resources outside the administrative fee it pays to the ASO/TPA.

Of the non Fee For Service models the ASO/TPA option allows the state to maintain tight oversight controls because performance accountability is tied to one contract. A transition to this service model is theoretically easier for providers and Medicaid clients because there is one point of contact for claims, prior authorizations, care coordination, and program related questions.

It is prudent to point out that in this model, the state relinquishes some control over the program and its role transforms from administration to oversight. The state's Medicaid programs like Program Integrity would need to shift its oversight of the dental program to effectively audit the ASO/TPA and provide the necessary oversight.

Carved-Out Managed Care

In a managed care model, the state contracts with two or more dental managed care organizations (DMCOs). The DMCOs are responsible for processing claims, reviewing prior authorizations, care coordination, and client outreach efforts in exchange for a paid or fixed monthly fee per enrollee. The DMCOs are responsible for analyzing and collecting data and can leverage that information to

manage contract and rates with providers, focus on specific evidence-based preventative services, and drive client outreach initiatives.

The state's role in this service delivery model transforms from health benefit administration to contract management. The state monitors the DMCO's interaction with providers and Medicaid clients ensuring the DMCOs are compliant with state laws and federal regulations. A solid contractual relationship allows the state to direct the DMCOs to maintain focus on one or more dental health initiatives. DMCOs have the ability to contract directly with providers allowing DMCOs to outcome-based incentives to drive the success for dental health initiatives. In addition to their experience, DMCOs also have the organizational infrastructure in place to support building provider networks, connecting clients to care, and achieving outcome based goals.

While there are advantages to a carved out delivery service model there are some additional challenges that the state must be prepared to address. If the state plans to auto-enroll Medicaid clients, CMS requires that the state contract with more than two DMCOs in each region. In areas where less than two DMCOs have contracts, Fee For Service would still be offered and managed care would be optional. Not to mention the state's dental program is administering and providing oversight to both a Fee For Service and managed care delivery service models.

Multiple DMCOs can add to the administrative burden of dental providers as they negotiate multiple contracts, complete provider enrollment and credentialing process, and navigate more than one claims and prior authorization system. Each DMCO would also be competing for the same dental providers and recruitment efforts can differ and overlap. DMCOs are generally required to match the state's fee schedule, but they are free to provide incentives beyond the state's reimbursement levels. Potentially, a savvy provider could negotiate a higher rate if a DMCO was willing to entertain that request, or a provider could choose to only sign a contract with one DMCO.

More than one DMCO provides choice for Medicaid clients, but it can also complicate matters if the client has established a relationship with a dental provider who may, or may not be, contracted with the managed care plan the client is enrolled in. This risk can be mitigated by adding continuity of care requirements to the contract and ultimately a Medicaid client can choose his or her managed care plan, but consideration should be given to this element.

It is also important to note that as the responsibility for claims and prior authorization processes shifts to the DMCOs the state relinquishes control and will no longer have direct access to claims data. This risk can be mitigated through strong contract language, but the fact remains the state is once removed from the process itself.

Carved-In Managed Care

Carved-In Managed Care, or integrated, managed care model the state contracts with managed care organizations (MCOs) to administer more than one Medicaid benefit package. In the State of Washington, Apple Health physical and behavioral health benefits are integrated, meaning a network of statewide MCOs administers both benefits. If dental benefits were carved-in to the existing Washington managed care model, each contracted MCO would administer physical, behavioral, and dental benefits for Apple Health clients. Like the carved-out model, MCOs are

responsible for processing claims, reviewing prior authorizations, care coordination, and client outreach efforts in exchange for a paid or fixed monthly fee per enrollee.

The advantages and potential risks outlined in the carved-out managed care section above apply to the carved-in model, but there are some additional considerations. Nationally, MCOs have more experience with physical health benefits than dental benefits. In the case where an MCO does not have the experience or ability to administer dental benefits they opt to sub-contract with DMCOs who can administer the dental benefit. The sub-contract relationship between an MCO and DMCO creates another level of benefit administration that can cause issues for providers and make it difficult for the state to provide the necessary oversight.

The successful integration of dental with another benefit could enhance access for Medicaid clients. Medical physicians often cite locating a dental provider as a barrier to successfully referring a Medicaid client.¹⁹ An MCO could leverage their existing network to reduce these barriers and provide a better connection between medical and dental providers. Potentially, this could enhance an MCOs ability to meet program goals, initiatives and implement efficiencies.

On the other hand, the portion of the per member per month rate paid to the MCO is much higher for physical health than dental. This financial inequity could lead MCOs to favor medical initiatives over dental and in turn, decrease the likelihood that dental initiatives successfully improve outcomes for Medicaid patients. As with any risk associated with a service delivery model, a strong contract that is closely monitored becomes the state's best tool to leverage to avoid these issues.

Administrative Costs

In a Fee For Service model the state is the only layer of benefit management and therefore retains control over the administrative costs of the program. While administrative costs of a Fee For Service program vary from state to state, HCA's fiscal year 2020 administrative budget is nearly \$4 million. "This budget includes contracted clinical personnel (\$1.1M) and internal operational personnel (\$0.8M) supporting dental and orthodontia authorizations, the dental director and several other clinical staff who manage the program and are responsible for policy (\$0.5M), management of the ABCD program (\$1M), and program integrity components such as the quality rating system, network adequacy validation, and other system assessments (\$0.5M)." (Fontana, Gerstorff, Lewis, & Saypoff, 2020)

Milliman's report (Appendix A) discusses the administrative costs associated with shifting portions of the dental program from a Fee For Service to another service delivery model. It is important to note that HCA's Program Integrity activities and fees, and the staff and vendor fees associated with ProviderOne would not decrease if the dental program shifted from Fee For Service to another service delivery model.

The Milliman report outlines other dental program areas that could be managed by an ASO, TPA, DMCO or MCO. It is difficult to forecast the administrative costs that might be associated with

¹⁹ (Geographic Access to Dental Care Washington)

another service delivery model as it would vary between both the model and the program elements administered by a third party(s).

Conclusion

Engrossed Substitute House Bill 1109 (2019) Section 211 (52) directed the Washington State Health Care Authority to end the carved out managed care procurement that the agency began in May 2018. HCA's implementation team gained valuable experience during the previous procurement that should be considered as the state contemplates potential changes to the Apple Health dental program.

The HCA implementation team's recommendations include a 24-month implementation timeline to allow for:

- Building a procurement plan and allowing ample time for each phase from requests for proposals to implementation.
- Provider engagement activities to inform and discuss change.
- Creating a range for bids that the agency and its authorizing authority are comfortable with.
- The building and execution of a comprehensive internal and external communication plan.
- Creating a change management committee to work with internal and external stakeholders.

In either managed care model, carved in or carved out, it is important to remember potential impacts to the state's foster care system. In a managed care model, Apple Health foster children could be enrolled in a plan that is available in one county, but unavailable in another county, causing continuity of care issues when the child is moved from one foster care placement to another. Foster parents who may have more than one child in their care could be navigating more than one managed care plan's network of dentists. One way to solve this issue would be to mirror the physical and behavioral health managed care model and enroll all of the state's foster children into one managed care plan. Another option is directing the agency to explore via a Request For Information and/or Proposal (RFI/RFP) to see what contractors would achieve the goals of patient and provider engagement, administrative simplicity, improved access to care.

The Apple Health dental program has implemented the ABCD program, changed the prior authorization process to reduce provider's administrative burden, and added tele-dentistry to increase access across the state. With these innovations, the dental program has made strides to meet the goal of increasing access and utilization, but as the data shows, there continues to be performance areas that need attention.

HCA's study of other Medicaid dental programs revealed that successfully increasing access and utilization has less to do with the service delivery model and more to do with tailoring a program that is reflective of the state's population and needs. If the goal is to increase not just access, but also drive utilization, the state should consider raising provider reimbursement rates and setting a long-term achievable goal for increasing access and utilization numbers. This approach may include a change to the service delivery model, but this approach could also include implementing an oral health strategy like identifying a dental home for Apple Health clients, employing a full-time dental

champion, or collaborating with local health jurisdictions to provide care coordination for the Medicaid population.



Appendix A: Medicaid Dental Program Models and Success Factors



MILLIMAN RESEARCH REPORT

Medicaid Dental Program Models and Success Factors

Research Supporting Washington State Legislative Report

PREPARED FOR THE WASHINGTON STATE HEALTH CARE AUTHORITY

January 2020

Joanne Fontana, FSA, MAAA
Catherine Lewis, FSA, MAAA, PMP

Jennifer Gerstorff, FSA, MAAA
Michael Saypoff, Actuarial Associate

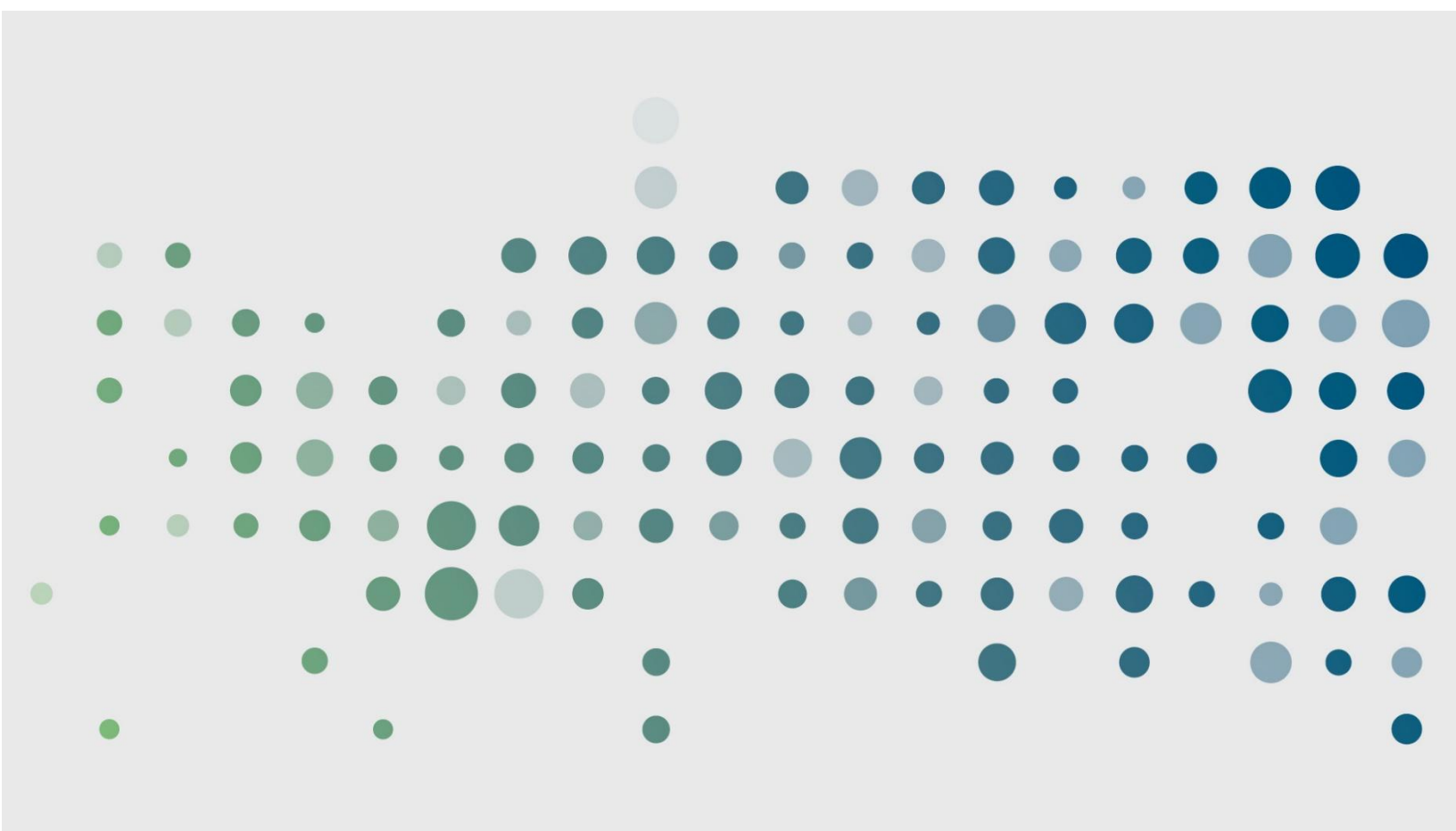




Table of Contents

EXECUTIVE SUMMARY.....	2
DELIVERY SYSTEM DEFINITIONS	2
<i>Fee-For-Service (FFS).....</i>	2
<i>Administrative Services Only/ Third Party Administrator (ASO/TPA).....</i>	2
<i>Managed Care Carve-In (“Carve-In”).....</i>	2
<i>Managed Care Carve-Out (“Carve-Out”)</i>	3
PROGRAM CONTRACTING, COSTS, AND SUCCESS FACTORS.....	3
SCOPE AND PURPOSE.....	5
KEY DEFINITIONS	5
WASHINGTON MEDICAID DENTAL PROGRAM: CURRENT STATE AND COMPARISON TO NATIONWIDE STATISTICS.....	7
PROGRAM BASICS.....	7
SPECIAL PROGRAMS.....	7
<i>Access to Baby & Child Dentistry (ABCD)</i>	7
<i>Oral Health Connections (OHC) Pilot Program</i>	7
<i>Other Benefit Expansions</i>	7
PROVIDER REIMBURSEMENT	7
<i>Medical Education Enhancements</i>	7
<i>FQHCs, RHCs, and Tribal Clinics</i>	8
KEY STATISTICS AND COMPARISON TO NATIONAL BENCHMARKS	8
<i>Provider Reimbursement Rates and Medicaid Participation</i>	8
<i>Child Dental Utilization.....</i>	9
<i>Adult Dental Utilization.....</i>	11
EXPLORATION OF VARIOUS MEDICAID DENTAL PROGRAM STRUCTURES	12
<i>Fee-For-Service (FFS).....</i>	12
<i>Administrative Services Only /Third Party Administrator (ASO/TPA).....</i>	12
<i>Carve-In.....</i>	12
<i>Carve-Out.....</i>	13
<i>Other</i>	13
MEDICAID DENTAL PROGRAM COSTS	13
BENEFIT COST SCENARIO ANALYSIS.....	13
ADMINISTRATIVE/OPERATIONAL COSTS BY PROGRAM TYPE	16
ANALYSIS OF MEDICAID DENTAL STATISTICS BY PROGRAM TYPE.....	17
CHILD UTILIZATION RATES BY DENTAL PROGRAM TYPE	18
LEVEL OF ADULT DENTAL BENEFITS BY DENTAL PROGRAM TYPE	19
PROVIDER REIMBURSEMENT RATES BY DENTAL PROGRAM TYPE.....	21
STATISTICS RELATED TO FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)	23
OTHER KEY SUCCESS FACTORS AND INNOVATIVE APPROACHES.....	25
PROVIDER-FOCUSED INITIATIVES.....	25
<i>Improving the provider experience</i>	25
<i>Leveraging non-traditional dental providers</i>	25
<i>Enabling the provider enrollment process.....</i>	26
BENEFICIARY-FOCUSED INITIATIVES.....	26
<i>Education and outreach.....</i>	26
<i>Establishing a dental home.....</i>	26
<i>Transportation.....</i>	26
<i>Community-based care.....</i>	27
<i>Partnerships with Dental Schools.....</i>	27
EMERGING AND INNOVATIVE MEDICAID DENTAL PROGRAM PRACTICES.....	27
<i>Use of dental therapists.....</i>	27

Teledentistry 28

Value-based payments (VBP) 28

Capitation payment withholds/incentives 29

Dental Champion 29

Connecting Oral and Medical Health 30

CONCLUSION AND IMPLICATIONS FOR STATE OF WASHINGTON **30**

ONE SIZE DOESN'T FIT ALL 30

MITIGATING RISKS OF ANY APPROACH 31

FFS 31

ASO/TPA 31

Carve-In 31

Carve-out 32

CAVEATS AND LIMITATIONS **33**

Executive Summary

The Washington State Health Care Authority (HCA) was tasked with developing a report to the legislature as required by ESHB 1109.SL Section 210 subsection 52 as detailed below:

“By November 15, 2019, the authority shall report to the governor and appropriate committees of the legislature a plan to improve access to dental services for Medicaid clients. This plan should address options for carve-in, carve-out, fee-for-service, and other models that would improve access and outcomes for adults and children. The plan should also include the cost for any options provided.”

This paper provides independent research and analysis to support HCA in developing their legislative report.

HCA currently administers the Medicaid dental program on a fee for service (FFS) basis. Compared with other states, Washington has Medicaid dental utilization rates for children well above the national average, bolstered by the state’s Access to Baby & Child Dentistry (ABCD) program promoting dental care and establishment of dental homes for young children. However, there remains a considerable gap in utilization levels between Medicaid and privately insured children, indicating the potential for further improvement in Medicaid child utilization. The proportion of dental providers in the state who participate in Washington’s Medicaid program is well below the national average, and the provider fee schedules for Medicaid dental services are low relative to other states and relative to Washington commercial reimbursement rates. Washington currently uses separate fee schedules for child versus adult dental services, with adult reimbursement relatively lower. Medicaid adult dental utilization levels are low and well below commercial utilization rates in the state, which may be correlated with lower provider reimbursement for such services.

DELIVERY SYSTEM DEFINITIONS

Medicaid dental care can be delivered using the following program types: Fee-For-Service (FFS), Administrative Services Only/ Third Party Administrator (ASO/TPA), Managed Care Carve-In, Managed Care Carve-Out, and certain other arrangements.

Fee-For-Service (FFS)

Under a FFS Medicaid dental program, dental benefits are administered by the state. Based on our research of other state programs, FFS programs are common and there is wide variation in their performance metrics. FFS programs can benefit from state-retained control over the program and fewer layers of administrative complexity. Improving on the existing FFS program in Washington could minimize disruption for providers and beneficiaries compared to considering other types of program administration.

Administrative Services Only/ Third Party Administrator (ASO/TPA)

The major difference between a FFS program and an ASO/TPA is that certain administrative functions are outsourced to an ASO vendor. The state retains the insurance risk and may retain some administrative responsibilities; the split of administration responsibilities between the state and the vendor can vary based on the specifics of the contract. ASO/TPA programs can benefit from the expertise and experience of a vendor for administrative and process improvements. Moving to an ASO vendor could keep beneficiary and provider disruption low while potentially streamlining administrative workflow. The cost of the program compared with the current FFS option would depend on the types of administrative functions outsourced and whether the vendor could commit to achieving program goals for a lower fee than HCA would incur for in-house management of those functions.

Managed Care Carve-In (“Carve-In”)

Under a Carve-In dental program, the state contracts with one or more medical managed care organizations (MCOs) who integrate (“carve in”) dental into their managed care programs. HCA pays these MCOs a fixed per-member, per-month capitation rate. The responsibility for insurance risk and administration of the Medicaid dental program is transferred to the MCO. Carve-In programs may benefit from synergies associated with medical and dental care being administered by the same organization. Additionally, the expertise and experience of an MCO vendor may help drive administrative improvements. Conversely, the risk of MCOs prioritizing medical initiatives over dental must be managed to ensure focus on dental-specific efforts. Relative to a FFS or an ASO/TPA program, moving to a Carve-In

program may cause disruption for beneficiaries and providers due to changes in the Medicaid provider network or changes in administrative processes that will need to be managed.

Managed Care Carve-Out (“Carve-Out”)

Under a Carve-Out dental program type, the state contracts with one or more dental managed care organizations (DMCOs), separate from any medical MCOs. Relative to a Carve-In, Carve-Out programs may benefit from the sole focus on dental care by a DMCO. The expertise and experience of a DMCO vendor also may help drive administrative improvements. Relative to a FFS or an ASO/TPA program, moving to a Carve-Out program may cause disruption for beneficiaries and providers due to changes in the Medicaid provider network or changes in administrative processes that will need to be managed.

PROGRAM CONTRACTING, COSTS, AND SUCCESS FACTORS

Under any program type, strong contracting and ongoing relationships between HCA and vendors are important to ensure the alignment of goals and achievement of desired outcomes. Contract provisions can include strict evaluation criteria and concrete target metrics for provider participation, utilization, and other statistics aligned with program goals. If multiple vendors are used under Carve-In or Carve-Out arrangements, the risk of disjointed administrative requirements may be managed through strong coordination and contracting to minimize beneficiary and provider confusion or frustration.

Increasing Medicaid dental utilization levels will very likely increase the cost of the program. We modeled illustrative scenarios that test the impact of increased utilization and reimbursement rates on the Washington Medicaid dental benefits budget. An isolated five percent improvement in adult dental utilization is worth approximately 1.7% of the Medicaid dental benefits budget, assuming reimbursement rates and all other current program components stay the same. As provider reimbursement rates will likely need to be increased to help facilitate such utilization, we also modeled the impact of a five percent adult dental utilization increase along with a ten percent increase in the adult dental fee schedule; this scenario results in a 2.6% increase in the Medicaid dental budget if Federally Qualified Health Centers (FQHCs) continue to be reimbursed at federal Prospective Payment System (PPS) rates, or 3.2% if FQHCs also receive the additional reimbursement. We also modeled a reimbursement scenario in which dental procedures for adults are reimbursed at the child dental fee schedule, which is approximately 28% higher than the adult fee schedule on a utilization-weighted basis. In this scenario, assuming adult utilization increases by 5%, the impact on the Medicaid dental benefits cost is 4.3% if FQHCs continue to be reimbursed at federal PPS levels or 5.9% if FQHCs also receive the higher reimbursement. While improved dental utilization rates are generally associated with increased program costs in the short term, there are potential longer-term benefits to improving the oral health of the covered population, including decreases in emergency room visits for dental issues and improved management of chronic diseases. A full analysis of this topic is beyond the scope of this report.

In addition to potential changes in the cost of benefits, administrative program costs may also be affected by changes in the Medicaid dental program construct. Under Washington’s current FFS arrangement, administrative functions are performed internally, with a fiscal year 2020 budget of approximately \$4 million. The state’s ProviderOne Medicaid Management Information System (MMIS) is used for provider interface, claims submission and payment, capitation payments, eligibility verification, prior authorization requests, non-Medicaid social services, and management reporting for planning and control; HCA pays a fixed monthly fee to its vendor for these services. As different Medicaid dental program constructs are considered, the administrative costs of the program could be shifted among contracted parties, and a key component of program design will be the determination of which program functions remain with the state or are provided by a vendor. Washington already demonstrates the ability to administer a Medicaid dental program successfully; consideration of vendors should focus on what administrative functions they might provide more efficiently as well as additional functions they can offer to improve the performance of the Medicaid dental program. Such functions might include provider network management and contracting, managed care initiatives, and furthering oral health connections with overall health.

We reviewed publicly available statistics on Medicaid dental programs across the country to assess the relative strengths of different program types. We found that the type of Medicaid dental program is not a strong predictor of its effectiveness. For example, the gap in dental utilization levels between Medicaid beneficiaries and the commercially

insured population vary widely by state, and it does not appear that any particular type of Medicaid program fares better in promoting dental utilization closer to commercial levels. We found that factors other than the Medicaid dental program set-up were more likely to correlate with improved utilization. One such factor is Medicaid dental provider reimbursement levels; a review of studies on the topic indicated that there exists a modest but statistically significant positive relationship between Medicaid payment rates and dental care utilization/access to dental care.¹

While reimbursement rates are important, they are not sufficient on their own to improve access to dental care. States that have successfully increased Medicaid dental utilization have several common key success factors, including:

- Provider focused reforms aimed at improving the provider experience and easing administrative burdens
- Leveraging non-traditional providers such as primary care physicians to provide basic preventative dental care
- Beneficiary access enablers including community-based care options, partnerships with dental schools, and improvements in transportation assistance to help beneficiaries access care in areas lacking in Medicaid dental providers
- Early establishment of “dental homes” for children in the Medicaid program
- Employing a Medicaid dental champion who takes on a public leadership role in prioritizing oral health

Some states are also experimenting with innovative approaches such as the use of teledentistry, value-based payment models, and use of mid-level dental providers.

Based on our research and analysis, there is not a definitive type of Medicaid dental program that outperforms others in improving access to dental care. Each state has unique needs and a unique foundation already in place to make improvements based on state priorities; there is no “one size fits all” model. Washington’s clear focus on oral health and high-performing program for Medicaid children lays the foundation for future improvements in the program. Bringing Washington’s adult utilization levels toward national norms and closer to the state’s commercially insured adults may be an appropriate area of focus going forward. Enhancing targeted adult outreach and education, transportation, and access to community-based care, as well as considering changes in provider reimbursement levels for services provided to adults, can help reduce barriers for some beneficiaries to receive the care they need.

¹ THE EFFECT OF MEDICAID PAYMENT RATES ON ACCESS TO DENTAL CARE AMONG CHILDREN. Buchmueller, T. et al. National Bureau of Economic Research. https://www.nber.org/papers/w19218.pdf?new_window=1. Accessed September 27, 2019.

Scope and Purpose

The Washington State Health Care Authority (HCA) was tasked with developing a report to the legislature as required by ESHB 1109.SL Section 210 subsection 52 as detailed below:

“By November 15, 2019, the authority shall report to the governor and appropriate committees of the legislature a plan to improve access to dental services for Medicaid clients. This plan should address options for carve-in, carve-out, fee-for-service, and other models that would improve access and outcomes for adults and children. The plan should also include the cost for any options provided.”

HCA contracted with Milliman to develop a white paper on the aforementioned Medicaid dental models, including examples of each model, cost considerations, and broader related indicators of success for Medicaid dental programs.

In this paper, we cover the following topics:

- ┆ The current Washington State Medicaid dental program and comparative statistics to other states
- ┆ Review of Medicaid dental program options, including:
 - Fee for service (FFS)
 - Administrative Services Only/Third Party Administrator (ASO/TPA)
 - Managed Care Carve-in
 - Managed Care Carve-out
 - Other
- ┆ Analysis of publicly available Medicaid dental statistics by dental program type
- ┆ Program cost considerations, including:
 - High level modeling of the operational and administrative costs associated with each type of Medicaid dental program
 - High level scenario analysis, across all program types, of the cost associated with various levels of increased dental utilization at various assumed unit cost levels
- ┆ Innovative approaches to oral health in the Medicaid population

KEY DEFINITIONS

To ensure mutual understanding of how we define each type of Medicaid dental program, we offer the following key terms, which we use throughout this paper.

FFS: state administers the Medicaid dental program, including all administrative functions such as provider contracting, claims adjudication, prior authorization, and policy management.

ASO/TPA: state contracts with a third party vendor who performs administrative functions, which may include network contracting, claims processing, reporting, and other services, while the state continues to directly fund claims payments for the Medicaid dental program.

Managed Care Carve-In (“Carve-In”): state contracts with currently contracted medical managed care organizations (MCOs) who administer the Medicaid dental program in addition to comprehensive Medicaid medical benefits, in exchange for a fixed capitation rate to cover the cost of medical and dental care as well as administration. The MCO may or may not subcontract out the dental administration, and subcontracting may or may not transfer risk to a dental vendor via a sub-capitation arrangement.

Managed Care Carve-Out (“Carve-Out”): state contracts with dental managed care organizations (DMCOs) who administer the Medicaid dental program for a fixed capitation rate that covers both dental claims and administration costs. These contracts are separate from any medical MCO contracts.

Other: a few states have unique Medicaid dental program arrangements that do not fit into one of the other categories.

We note that our classification of states is subjective, and others may categorize state programs differently. Also, state Medicaid dental programs change over time; we believe our information is current as of September 2019 but we recognize that we may not have captured recent changes in state Medicaid dental programs.

Washington Medicaid Dental Program: Current State and Comparison to Nationwide Statistics

PROGRAM BASICS

Apple Health, the state Medicaid program administered by the HCA in Washington State, provides dental coverage for approximately 2 million beneficiaries. Like all states, HCA's program covers comprehensive dental benefits for children, and HCA also offers comprehensive coverage for adults as an optional State Plan benefit. The program operates under the state's FFS delivery system, with a state budget of approximately \$200 million. Adding in federal match dollars and federally funded payments to Federally Qualified Health Centers (FQHCs) brings the total cost of benefits to nearly \$400 million as of state fiscal year 2018.²

SPECIAL PROGRAMS

HCA administers several special programs aimed at ensuring access to dental care for Medicaid beneficiaries.

Access to Baby & Child Dentistry (ABCD)

This program for children through age 5 “connects low-income families with dentists who know how to care for young kids, preventing tooth decay early and educating parents about how to take good care of their child’s teeth”³. The program brings together various state agencies and community resources to address common barriers to early childhood dental care, such as assistance with transportation, interpreter services, outreach, and education for families and providers. It operates via public/private partnerships among HCA, the state health department, the University of Washington School of Dentistry, Arcora, the state’s dental association, and other local community organizations. Dentists and primary care medical providers participating in the program are eligible for enhanced reimbursement rates for services to this population⁴. Since 1999, ABCD has increased the proportion of eligible children receiving services from 21% to 52%.⁵

Oral Health Connections (OHC) Pilot Program

A three-year pilot effective January 2019 in three counties aims to test the effect of enhanced oral health services on the overall health of pregnant women and of adults with diabetes. Participating dentists receive enhanced reimbursement for delivery of an expanded set of preventive dental services.⁶

Other Benefit Expansions

Apple Health also provides additional services above the state’s standard adult Medicaid dental benefits for other vulnerable Medicaid populations, including clients of the state’s Developmental Disabilities Administration (DDA), and residents of alternate living facilities or nursing homes.

PROVIDER REIMBURSEMENT

HCA’s provider reimbursement is based on separate Medicaid dental fee schedules for child and adult services, with child fees being relatively higher. HCA also provides enhanced funding for safety net providers who accept a disproportionate share of Medicaid beneficiaries.

Medical Education Enhancements

Supplemental payments which increase reimbursement levels to the Average Commercial Rate are made to the University of Washington School of Dentistry (UWSOD) to ensure patient access.⁷ HCA also offers a clinical training allowance for services performed in UWSOD’s Dental Education in the Care of Persons with Disabilities (DECOD)

² Dental payments by service type. <https://www.hca.wa.gov/about-hca/dental-data>. Accessed October 5, 2019

³ <http://abcd-dental.org/>. Accessed August 29, 2019.

⁴ Access to Baby and Child Dentistry Billing Guide, Accessed July 1, 2019. <https://www.hca.wa.gov/assets/billers-and-providers/abcd-dental-bi-20190701.pdf>

⁵ <http://abcd-dental.org/>. Accessed August 29, 2019.

⁶ <https://www.hca.wa.gov/assets/billers-and-providers/Oral-Health-Conn-Pilot-Proj-BI-20190101.pdf>; Accessed October 5, 2019

⁷ <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Downloads/WA/WA-11-021-179.pdf>; Accessed October 5, 2019

Clinic, which is a teaching institute that “provides dental care that is not otherwise available in the community for patients with developmental or acquired disabilities”.⁸

FQHCs, RHCs, and Tribal Clinics

Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Tribal Clinics are community-based providers who offer multiple types of services, including dental services, and serve patients regardless of their ability to pay, which leads to a disproportionate share of Medicaid, Medicare, and uninsured patients relative to private dental practices. These clinics generally receive a prospective payment system (PPS) encounter payment intended to cover all services provided during a patient visit (encounter). PPS encounter rates are calculated annually by the state based on provider cost reports and are intended to cover the clinic’s operating cost. Under a managed care program, these clinics would continue to receive enhanced payments, which may be operationalized in several different ways.

KEY STATISTICS AND COMPARISON TO NATIONAL BENCHMARKS

We reviewed the Washington Medicaid dental program compared to national benchmarks using several publicly available sources. The sources are from different time periods and may not always reflect the most current information in the state or for the nation as a whole, but we believe that they all provide useful context.

Provider Reimbursement Rates and Medicaid Participation

In 2015, Washington had only 19% dentist participation in Medicaid or CHIP for child dental services, compared with 38% nationally.⁹ Based on a recent survey of Washington dental providers conducted by WA HCA and shared with Milliman, dentists in the state cite low reimbursement rates as a primary reason for low Medicaid provider enrollment, and rates were ranked as the number one most important area of potential change to improve participation.¹⁰

According to a study by the American Dental Association Health Policy Institute, 2016 nationwide average FFS reimbursement rates for Medicaid child dental services were approximately 61.8% of the reimbursement rates for commercially-insured children. The comparable number for Washington was 40.4%, well below the average. For adult dental services, Medicaid fees are 46.1% of commercial fees nationally, and 32.4% in Washington. The low Medicaid reimbursement rates for adults on both an absolute basis and relative to commercial fees may help to explain the lower-than-average Medicaid provider participation rates and, as a result, low adult dental utilization levels.¹¹

According to a 2015 infographic from the American Dental Association, approximately 89% of publicly insured children in Washington live within 15 minutes of a Medicaid dental provider. However, for approximately 2/3 of these children, the Medicaid dental provider to Medicaid beneficiary ratio is above 500:1.¹²

⁸ <https://dental.washington.edu/decod/>; Accessed October 5, 2019

⁹ Dentist Participation in Medicaid or CHIP. American Dental Association.

https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0318_1.pdf?la=en. Accessed September 24, 2019.

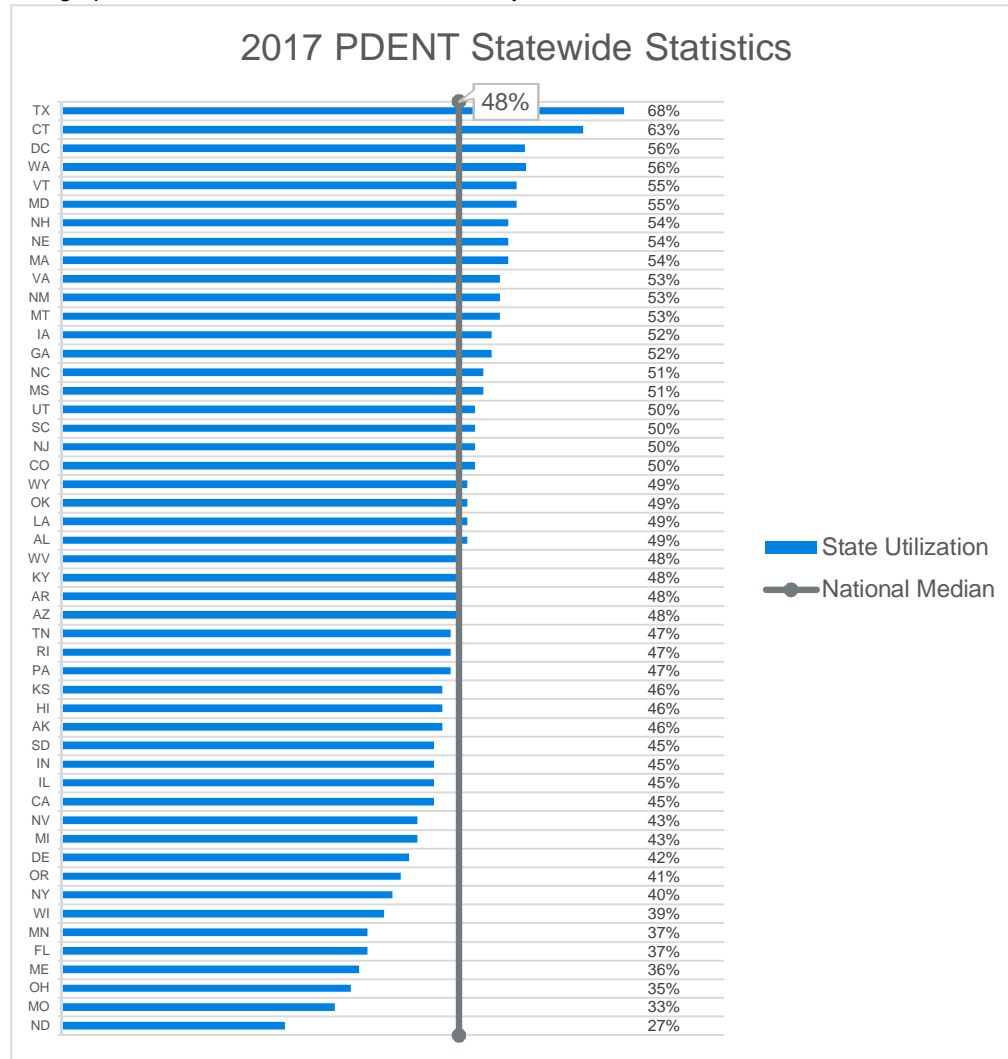
¹⁰ Dental Apple Health Survey Results. Washington State Health Care Authority.

¹¹ A Ten-Year, State-by-State, Analysis of Medicaid Fee-for-Service Reimbursement Rates for Dental Care Services. Nasseh, K, Vujicic, M, and Yarbrough, C. American Dental Association Health Policy Institute Research Brief, October 2014.

¹² Geographic Access to Dental Care. American Dental Association. <https://www.ada.org/en/science-research/health-policy-institute/geographic-access-to-dental-care>. Accessed September 24, 2019.

Child Dental Utilization

Despite lower than average dentist participation in the Medicaid program, Washington ranks as a top five state for child Medicaid preventive dental utilization. The 2017 CMS P Dent (Percentage of Eligibles Who Received Preventative Dental Services: Ages 1-20) metric for Washington indicates that 56% of eligible Medicaid children received at least one preventive dental service during the year. This is compared to the national median of 48%.¹³ The graphic below summarizes 2017 P Dent by state.¹⁴



Washington also leverages non-traditional types of providers to increase access to dental care. Form CMS-416, line 12f captures the total number of eligibles receiving oral health services by a non-dentist provider. According to the 2017 CMS-416 data set, 7.25% of Medicaid enrolled children in Washington received oral health services from non-dental providers, compared with the national average of 4.59%.¹⁵ A “non-dentist provider” is any qualified health care practitioner who is neither a dentist nor providing services under the supervision of a dentist.¹⁶

¹³ Percentage of Eligibles Who Received Preventive Dental Services: Ages 1-20. Center for Medicare & Medicaid Services. <https://www.medicare.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/dental-services/index.html> . Note that eligibility is based on individuals enrolled in Medicaid or CHIP programs for at least 90 continuous days. The graphic does not include utilization data for the state of Idaho.

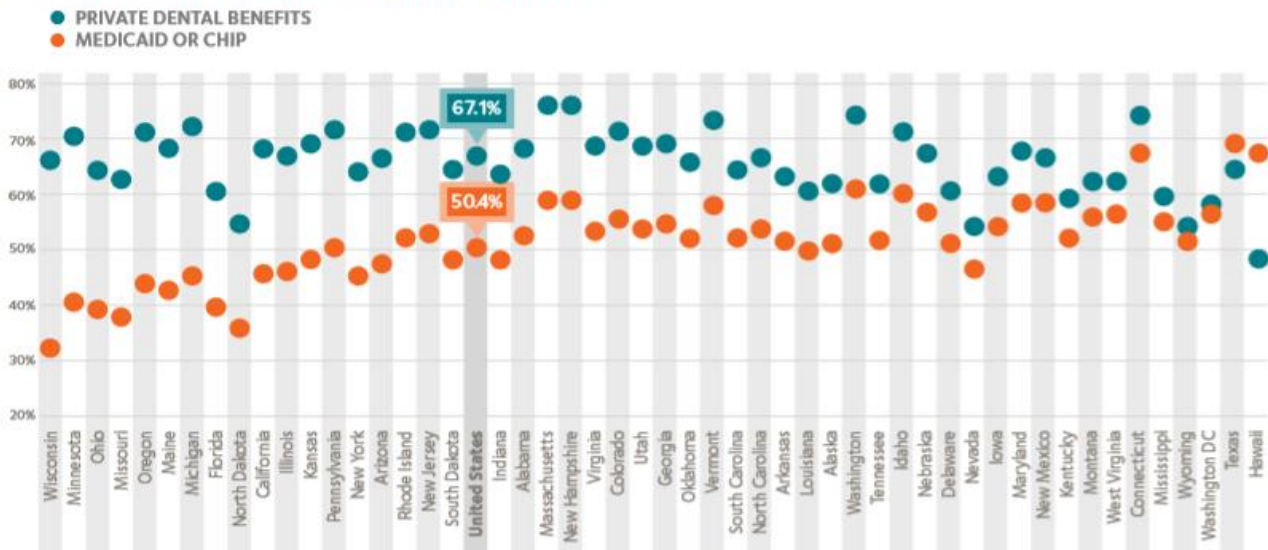
¹⁴ Ibid.

¹⁵ Early and Periodic Screening, Diagnostic, and Treatment. Center for Medicare & Medicaid Services. CMS-416 (2017): line 12f/line 1b.

¹⁶ <https://www.medicare.gov/medicaid/benefits/downloads/cms-416-instructions.pdf>. Accessed September 23, 2019

In addition to considering child dental utilization rates in the absolute, it is also important to review the differences in utilization rates between Medicaid and commercially-insured populations in a given state. A state with high absolute Medicaid utilization compared to other states may still have low utilization compared with commercially insured people in the same state. Conversely, a state with low Medicaid dental utilization may also have low commercial utilization, indicating only small differences in access between Medicaid and commercial members in that state. A larger-than-average gap between Medicaid and commercial utilization levels may indicate opportunity for a state to improve Medicaid utilization to move it closer to that of commercially insured people in the same state. The American Dental Association Health Policy Institute provided the infographic below to illustrate the utilization gap between commercially insured children and children in Medicaid in 2016¹⁷:

DENTAL CARE USE AMONG CHILDREN BY STATE, 2016



Data analysis and graphic design courtesy of the ADA Health Policy Institute

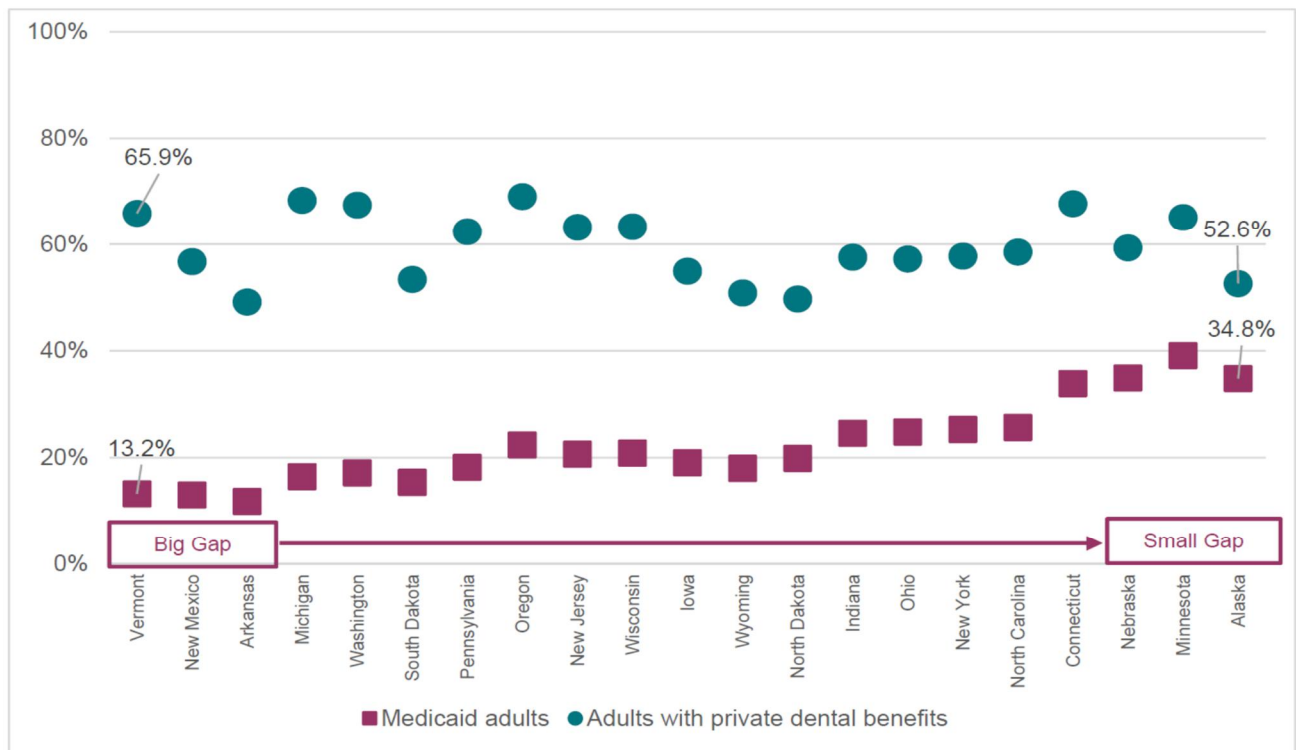
The United States averages a 67.1% utilization rate for commercially insured children and a 50.4% rate for children on Medicaid, indicating a gap, or difference, of 16.7%. Washington (about two-thirds of the way to the right of the chart) has both commercial and Medicaid utilization rates above the national average, and a smaller gap than the national average. That being said, a considerable gap in utilization – over 10% -- does exist, indicating that WA may still have opportunity to improve child Medicaid dental utilization to better align with commercial utilization levels in the state. 17 states have smaller utilization gaps than Washington; as you can see from the chart, the raw Medicaid and commercial utilization levels in those states vary widely. Connecticut appears to have commercial utilization close to Washington's, with a much smaller gap between Medicaid and commercial levels.

¹⁷ Dental Care Use Among Children: 2016. American Dental Association. https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIGraphic_0718_1.pdf?la=en. Accessed September 24, 2019.

Adult Dental Utilization

While we observe above-average performance metrics for Washington’s Medicaid child utilization, the adult Medicaid dental utilization is well below average. According to a research brief by the American Dental Association Health Policy Institute, in 2013 (the most recent year for which we found adult Medicaid utilization reported consistently across states), adult Medicaid dental utilization averaged 22.3% across the 21 states identified as having limited or extensive adult dental benefits at that time. In comparison, Washington’s adult Medicaid dental utilization rate was 17.2%, the fifth lowest of the 21 states. Washington also showed a roughly 50% utilization gap relative to adults with commercial coverage, compared with an average utilization gap of approximately 37%.¹⁸ The chart below is reproduced from Figure 6 of the research brief.¹⁹

Figure 6: Relative Gap in Dental Care Utilization between Medicaid-Enrolled Adults and Adults with Private Dental Benefits, 2013



Source: HPI analysis of Truven Health Analytics MarketScan® Research Databases and Medicaid data from Medicaid Statistical Information System provided by CMS. **Notes:** States are ordered from left to right according to the relative gap between Medicaid-insured adults and adults with private dental benefits. Population is based on adults continuously enrolled in Medicaid or a private dental plan for 90 days. The states plotted provide adult Medicaid dental benefits.

Data analysis and graphic design courtesy of the ADA Health Policy Institute

Based on our discussions with HCA, we understand that from 2010 to 2013, Washington had a reduced adult dental Medicaid benefit, consisting of only emergency care, with additional services for pregnant women. As such, the use of 2013 data is not ideal to assess how the state’s adult utilization rate compares to others. HCA provided additional utilization data for years 2014 and beyond, and we have observed that since the adult benefit was reinstated, utilization has been approximately 22% to 22.5%²⁰. Considering this information in combination with the graphic above, Washington’s absolute dental utilization rate roughly consistent with the average, but with a larger-than-average gap between Medicaid and commercial utilization rates.

¹⁸ Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrow, Remains Large for Adults. Vujcic, M and Nasseh, K. American Dental Association Health Policy Institute Research Brief, December 2015.

¹⁹ Ibid.

²⁰ <https://www.hca.wa.gov/assets/free-or-low-cost/costandutilizationsummary.pdf>

Exploration of Various Medicaid Dental Program Structures

In this section we discuss different approaches to structuring state Medicaid dental programs. We did not complete a comprehensive review of all 50 states' Medicaid dental programs; however, we did review state examples of each type of program via publicly available sources, survey responses provided to us by WA HCA, and internal discussions with Milliman consultants.

In the table below we provide a categorization of states according to the dental program type currently in place. Please note that there is overlap between categories and many states do not fit neatly into one approach. Many states have nuanced programs, and as a result the categorizations below may not be completely representative of a particular state's approach, but rather represent our best attempt to categorize each state appropriately. It is also important to note that state program approaches can vary over time; we believe that our information is current as of mid-year 2019 but may not include new or recent initiatives.

FIGURE 1: MEDICAID DENTAL PROGRAM TYPES BY STATE

PROGRAM TYPE	LIST OF STATES
FFS	Alabama, Alaska, Delaware, Illinois, Indiana, Maine, Michigan, Missouri, Montana, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Utah, Washington, Virginia, Wisconsin, Wyoming
ASO/TPA	California, Colorado, Connecticut, Hawaii, Illinois, Maryland, Massachusetts, South Carolina, South Dakota, Virginia
Carve-In	Arizona, Georgia, Illinois, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Vermont, West Virginia, Wisconsin, District of Columbia
Carve-Out	Arkansas, California, Florida, Idaho, Iowa, Louisiana, Nebraska, Nevada, Rhode Island ²¹ , Tennessee, Texas, Utah
Other	Oregon, Vermont

Fee-For-Service (FFS)

A Fee-For-Service (FFS) Medicaid dental program type is entirely administered by the state. In a FFS program, the state Medicaid agency establishes provider fee schedules and pays providers directly for services delivered. As a result, the state takes the financial risk for providing dental benefits and can be exposed to fluctuations in claims payment levels. That being said, dental claims are generally fairly predictable and under a FFS program the state would have ready access to all necessary data to estimate prospective costs. Under a FFS program type Medicaid enrollees are responsible for locating a FFS provider willing to accept Medicaid patients, and can choose to see any participating provider who is accepting patients. Administrative processing such as claims processing, claims payment, provider credentialing, etc., is under state authority.²² Washington currently administers its dental benefit through a FFS program.

Administrative Services Only /Third Party Administrator (ASO/TPA)

Under an ASO/TPA arrangement, a vendor provides various administrative functions associated with running the state dental program, for a membership-based fee. Functions may include network development, credentialing, beneficiary outreach, claims processing, prior authorization, and other responsibilities. The state would retain the insurance or claims risk associated with the program, and could retain some administrative responsibilities depending on the specifics of the ASO contract.

Carve-In

Under a carve-in program, a state contracts with one or multiple medical managed care organizations (MCOs) who take risk for, and administer, the Medicaid dental program as a component of the comprehensive managed care program. In this sense the dental benefit is "carved in" to the medical program. The managed care organization (MCO) operates under a risk-based contract with the state to provide a specific set of benefits to plan beneficiaries.

²¹ Note that in Rhode Island, children born on or after 2000 are under a dental managed care program. Adults are covered via a FFS arrangement. Many of the statistics in this paper rely on CMS-416 data, which are for children only. For the purposes of paper, we classify Rhode Island as a carve-out.

²² <https://ncd.gov/policy/appendix-glossary-terms>. Accessed September 24, 2019.

The state pays a fixed per-member, per-month (PMPM) capitation rate; as a result, claim fluctuation risk is shifted from the state to the MCO for the fiscal period. However costs could still vary from year to year as the capitation rates are generally updated annually to reflect emerging experience. It is possible that an MCO may subcontract out the dental benefits to a dental managed care organization.

Carve-Out

A carve-out arrangement refers to a dental program in which the state contracts directly with a dental managed care organization (DMCO) to administer the dental benefit, separate from any medical managed care contracts. The state pays a fixed PMPM capitated payment to the DMCO, which is generally renegotiated annually. In turn, the DMCO assumes the risk associated with claim fluctuation and also provides administrative services. This type of program can sometimes be referred to as a PAHP (prepaid ambulatory health plan).

Other

Vermont and Oregon have unique variations of carve-in arrangements that we have categorized as “Other”.

Vermont utilizes one medical MCO for its Medicaid population; in a unique waiver arrangement, the state itself is the MCO.²³ The state-run MCO works with Northeast Delta Dental (NEDD), although we do not have full information on whether NEDD takes insurance risk or is an ASO vendor. Vermont’s Medicaid dental reimbursement rates are set in the legislature and include incentives using alternative payment methodologies. The adult dental benefit has a \$510 annual limit and a \$3 copay.²⁴ Vermont Medicaid has a child outreach program, a revenue neutral care coordination/ACO model for medical and strives to be a single payer.

Oregon has a Coordinated Care Organization (CCO) system for Medicaid. A CCO system can be considered a “carve-in” model; the state contracts with an agency to deliver both medical and dental benefits. Oregon has 15 regional CCOs, and each of the CCOs affiliates with one or more dental plans. Compared with MCOs, CCOs have an increased focus on prevention, chronic disease management, and population health. Similar to an MCO, CCOs may subcontract with dental plans and within these contracts specific provisions about dental are detailed. Oregon has several pilot programs currently underway regarding emergency room diversion, integrating dental hygienists into primary care settings and increasing the use of teledentistry. According to a case study by the National Academy for State Health Policy, key themes have emerged from Oregon’s experience with the CCO:

*There is clear recognition of oral health as a component of whole-person care; financial incentives provide motivation for stakeholders to bridge historically separate systems; and fostering pilots that test the potential for realized savings from capitalizing on the links between oral health and overall health is a valuable state tool.*²⁵

Medicaid Dental Program Costs

BENEFIT COST SCENARIO ANALYSIS

In this section we present simple illustrative cost scenarios to show how the stated goal of improving access to Medicaid dental services could affect cost. The scenarios in this section incorporate potential changes in dental benefit costs only and do not reflect administrative cost impact associated with program changes. Based on our research, we do not believe it is appropriate to model different dental program types as having measurably different dental benefit costs; we therefore provide cost modeling intended to broadly hold true across any type of Medicaid dental program. Our goal is to illustrate the order of magnitude of cost changes in the Medicaid dental budget associated with improved utilization of dental services. Our baseline cost estimates are from calendar year 2017 claims data provided by HCA²⁶ and reflect total benefit costs regardless of federal or state funding source.

²³ <https://dvha.vermont.gov/qual-man-plan-dvha-05.15.pdf>, Accessed September 5, 2019.

²⁴ <https://www.greenmountaincare.org/health-plans/medicaid#Dental>. Accessed September 5, 2019.

²⁵ <https://nashp.org/case-study-oral-health-and-oregons-coordinated-care-organizations/>

²⁶ Managed Care Dental RFP Data Book, prepared for the State of Washington Health Care Authority, dated May 14, 2018

Our scenarios focus on the adult Medicaid population, as we believe that is the area with the greatest potential for improvement, but there could be a downstream impact on the child population as well which we did not model. The scenarios assume that the size of the covered population remains stable.

First, we consider a simple scenario in which Medicaid dental utilization for the adult population increases by 5%, as we believe this to be a reasonable short-term goal for the program.

SCENARIO 1: ILLUSTRATIVE COST IMPACT TO MEDICAID DENTAL COST IF UTILIZATION INCREASES BY 5% FOR ADULTS ONLY

BENEFIT COST TYPE	BASELINE (\$MILLIONS)	SCENARIO 1 (\$MILLIONS)	\$\$ CHANGE	% CHANGE
Adult Dental Benefit Cost	\$ 51.7	\$ 54.3	\$ 2.6	5.0%
Child Dental Benefit Cost	\$ 182.0	\$ 182.0	\$ 0.0	0.0%
TOTAL BENEFIT SERVICE COST	\$ 233.7	\$ 236.3	\$ 2.6	1.1%
Adult FQHC Supplemental Payments	\$ 70.3	\$ 73.8	\$ 3.5	5.0%
Child FQHC Supplemental Payments	\$ 54.7	\$ 54.7	\$ 0.0	0.0%
TOTAL FQHC SUPPLEMENTAL COST	\$ 125.0	\$ 128.6	\$ 3.6	2.9%
TOTAL DENTAL BENEFIT COST	\$ 358.8	\$ 364.9	\$ 6.1	1.7%

An isolated 5% increase in adult dental utilization results in approximately \$6.1 million in additional benefit cost to the state, representing 1.7% of the Medicaid dental benefits budget.

We believe it is unlikely that a measurable change in utilization will occur without some level of adjustment to reflect increased provider reimbursement to Medicaid dental providers for adult services. As such, Scenario 1 serves as an illustrative starting point but is unrealistic for budget estimation purposes. In Scenario 2, we assume that the Washington adult dental fee schedule increases by 10% across the board, which, along with other dental-focused initiatives, facilitates an estimated 5% increase in adult dental utilization. This is an illustrative example; we are not indicating that this relationship between reimbursement and utilization will hold true, but believe it to be a reasonable assumption for simple scenario modeling purposes. For simplicity, we also assumed that FQHC encounter reimbursement will remain consistent with current PPS rates; as such, the increase in the FFS payment to FQHCs for adult dental services is offset in the FQHC supplemental payment such that the total reimbursement per FQHC encounter remains at the same historical PPS level. In this analysis we used the 2017 Washington adult Medicaid dental fees as a baseline; there have been minor changes in the schedule since that time but they do not have a material impact.

SCENARIO 2: ILLUSTRATIVE COST IMPACT TO MEDICAID DENTAL COST IF UTILIZATION INCREASES BY 5% AND REIMBURSEMENT INCREASES 10% (FOR ADULTS ONLY)

BENEFIT COST TYPE	BASELINE (\$MILLIONS)	SCENARIO 2 (\$MILLIONS)	\$\$ CHANGE	% CHANGE
Adult Dental Benefit Cost	\$ 51.7	\$ 59.7	\$ 8.0	15.5%
Child Dental Benefit Cost	\$ 182.0	\$ 182.0	\$ 0.0	0.0%
TOTAL BENEFIT SERVICE COST	\$ 233.7	\$ 241.7	\$ 8.0	3.4%
Adult FQHC Supplemental Payments	\$ 70.3	\$ 71.8	\$ 1.5	2.1%
Child FQHC Supplemental Payments	\$ 54.7	\$ 54.7	\$ 0.0	0.0%
TOTAL FQHC SUPPLEMENTAL COST	\$ 125.0	\$ 126.5	\$ 1.5	1.2%
TOTAL DENTAL BENEFIT COST	\$ 358.8	\$ 368.2	\$ 9.4	2.6%

Scenario 2 represents a more likely estimation of the increase in benefit costs, at approximately \$9.5 million or 2.6% of the Medicaid dental budget.

In Scenario 3, we also modeled a scenario in which the FQHCs are paid at the enhanced reimbursement rate for individual services in addition to the full supplemental payment amount, which is calculated as the difference between the PPS rate and the state FFS fee schedule for services provided within the encounter, which is how the Washington medical managed care program operates. This scenario results in a budget impact of 3.2% as shown in the table below.

SCENARIO 3: ILLUSTRATIVE COST IMPACT TO MEDICAID DENTAL COST IF UTILIZATION INCREASES BY 5%, FFS REIMBURSEMENT INCREASES 10%, AND FQHC SUPPLEMENTAL PAYMENTS ARE NOT REDUCED TO OFFSET ENHANCED FFS RATES (FOR ADULTS ONLY)

BENEFIT COST TYPE	BASELINE (\$MILLIONS)	SCENARIO 3 (\$MILLIONS)	\$\$ CHANGE	% CHANGE
Adult Dental Benefit Cost	\$ 51.7	\$ 59.7	\$ 8.0	15.5%
Child Dental Benefit Cost	\$ 182.0	\$ 182.0	\$ 0.0	0.0%
TOTAL BENEFIT SERVICE COST	\$ 233.7	\$ 241.7	\$ 8.0	3.4%
Adult FQHC Supplemental Payments	\$ 70.3	\$ 73.8	\$ 3.5	5.0%
Child FQHC Supplemental Payments	\$ 54.7	\$ 54.7	\$ 0.0	0.0%
TOTAL FQHC SUPPLEMENTAL COST	\$ 125.0	\$ 128.5	\$ 3.5	2.8%
TOTAL DENTAL BENEFIT COST	\$ 358.8	\$ 370.2	\$ 11.4	3.2%

As stated previously, Washington's Medicaid dental provider fees vary based on whether an adult or child is being treated, with higher fees for child services. We defined Scenarios 4 through 6 to use the same baseline shown in the prior three scenarios, but we introduced testing the unit cost impact of setting Washington's 2017 Medicaid adult dental fee schedule equal to the child fees. If providers were to be reimbursed at the 2017 child fee schedule for adult dental services, the average unit cost of adult services would increase by 28%, which, prior to any assumed increase in utilization and assuming FQHCs continue to be paid according at the same PPS rates, would increase the estimated Medicaid dental benefit cost by 2.5%. Adding in the impact of an assumed adult utilization change of 5%, and then additionally the assumption that FQHCs would also receive the enhanced payment rate beyond PPS, would affect Medicaid dental benefit costs by 4.3% and 5.9% respectively. We note that the 5% change in utilization is an illustrative assumption that we applied consistent with the prior scenarios to avoid introducing additional complexity to the modeling. It is reasonable to expect that if reimbursement were to increase 28%, utilization may increase more than 5%; however, it is difficult to isolate the change in utilization directly associated with a major change in provider reimbursement level, as so many other variables factor into ultimate utilization rates. Development of such assumptions is beyond the scope of this report.

SCENARIOS 4 – 6: ADDED TESTING VARIABLE OF ADULT FEE SCHEDULE AT CHILD FEE SCHEDULE LEVELS

SCENARIO	MEDICAID DENTAL COST INCREASE (\$MILLIONS)	MEDICAID DENTAL COST INCREASE (%)
Unit Cost: Reimburse Adult FFS Procedures at Child Fee Schedule Utilization: No Change FQHC: Reimburse at PPS	\$8.9	2.5%
Unit Cost: Reimburse Adult FFS Procedures at Child Fee Schedule Utilization: 5% Increase in Adult Utilization FQHC: Reimburse at PPS	\$15.5	4.3%
Unit Cost: Reimburse Adult FFS Procedures at Child Fee Schedule Utilization: 5% Increase in Adult Utilization FQHC: Reimburse at Enhanced FFS Rate	\$21.3	5.9%

Increasing adult dental utilization may have downstream effects on the broader Medicaid dental program; specifically, child utilization may be affected even without any significant additional child-focused initiatives. Studies suggest that mothers who increase their utilization of Medicaid dental benefits will improve their children's utilization as well.²⁷ We have not attempted to explicitly model the effect of program improvement initiatives on child utilization.

Additionally, while utilization may initially rise across the board as more beneficiaries seek care, the long-term total costs for particular types of dental services may fall as the oral health of the population improves, assuming that dental benefits remain intact and access remains consistent, and that the covered population remains consistent. Medicaid dental services can be categorized into the following four classes:

Class I: Preventative and diagnostic services (oral exams, cleanings, x-rays, fluoride, sealants)

Class II: Basic services (extractions, oral surgery, restorations, periodontics, endodontics)

Class III: Major services (prosthodontics such as inlays/onlays/crowns, dentures, bridges)

(Class IV Orthodontics is an additional class of service but this is not covered under Washington's adult Medicaid benefit.)

In the short term, as increased access to care allows adults who previously have not sought out dental services to do so, utilization across all classes of service is likely to increase. In the longer term, under a consistent improved oral health program for this population, utilization of Class II and III services may start to subside as major unmet oral health issues have been addressed and access to routine preventive care can reduce the need for more expensive services going forward. There are also potential longer-term benefits to improving the oral health of the covered population including decreases in emergency room visits for dental issues and better management of chronic diseases. A full analysis of this topic is beyond the scope of this report.

As HCA moves forward in determining the Medicaid dental program construct and goals, we suggest further modeling to provide more focused cost estimates than the illustrative scenarios included in this paper.

ADMINISTRATIVE/OPERATIONAL COSTS BY PROGRAM TYPE

Under Washington's current FFS arrangement, administrative functions are performed internally, with a fiscal year 2020 budget of almost \$4 million. This budget includes contracted clinical personnel (\$1.1M) and internal operational personnel (\$0.8M) supporting dental and orthodontia authorizations, the dental director and several other clinical staff who manage the program and are responsible for policy (\$0.5M), management of the ABCD program (\$1M), and program integrity components such as the quality rating system, network adequacy validation, and other system assessments (\$0.5M).

The state's ProviderOne Medicaid Management Information System (MMIS) is used for provider interface, claims submission and payment, capitation payments, eligibility verification, prior authorization requests, non-Medicaid social services, and management reporting for planning and control; HCA pays a fixed monthly fee to its vendor for these services. In addition to direct claim costs, some third party contracts related to dental care are also included in the cost of benefits in ProviderOne; some examples include contracted mobile anesthesia vendors, the training allowance for UWSOD's Dental Education in the Care of Persons with Disabilities (DECOD) program, and training and education costs associated with the Oral Health Connections Pilot Program.

As different Medicaid dental program constructs are considered, the administrative costs of the program could be shifted among contracted parties. A key component of program design will be the determination of which program functions remain with the state or are provided by a vendor, whether that vendor is a TPA, MCO, or DMCO. Washington already demonstrates the ability to administer a Medicaid dental program successfully; consideration of vendors should focus on what administrative functions they might provide more efficiently as well as additional functions they can offer to improve the performance of the Medicaid dental program.

Based on our discussions with HCA and reviews of other states' processes, we believe the following considerations will be important in the vendor contracting process:

²⁷ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4821415/>

- For each administrative process, would outsourcing to a vendor improve efficiency -- i.e. would the need for internal resources be reduced by more than what it would cost to pay a vendor for that service, with equal or better results for the program?
- **Program integrity** activities would remain intact even if an alternative program structure were pursued, as CMS requires states to comply with program integrity requirements.
 - **The ProviderOne contract** would remain under alternate dental program constructs, as the state would still need to collect, analyze and report on service encounters even though the state would not be adjudicating claims. Internal tracking of encounters is critical to support the development of the capitation rates paid to managed care entities; it is also required under federal regulation to support program integrity and oversight, quality and access evaluation, FQHC supplemental payment calculation, and other reporting.
 - **The fee paid to ProviderOne** could change, depending on the scope of activity expected within the system. Also, some of the contracts supporting services related to dental care (e.g, mobile anesthesia) could become vendor responsibilities depending on the specifics of the vendor contract.
 - **Authorization processes** are currently handled via internal HCA staff as well as contract staff; exploration of vendor capabilities in this area could uncover areas for potential cost reductions and/or process improvements.
- What services can a vendor provide that could add value to the Medicaid dental program and are not currently provided by or focused on by HCA today? These may include:
- **Member education and outreach**, especially to adult beneficiaries: HCA's efforts under the ABCD program for young children are significant, but similar efforts have not been broadly explored for beneficiaries outside of that program.
 - **Provider network management and contracting**: Vendors may have, or may have the expertise to develop, contracts with dental providers above and beyond the standard Medicaid network to increase access for Washington Medicaid beneficiaries.
 - **Managed care initiatives**: Vendors may be able to provide a focus on optimizing utilization toward preventive care and reducing unnecessary utilization.
 - **Furthering connections between oral and physical health**: HCA's OHC pilot program takes a step toward assessing the potential outcomes improvement associated with incorporating oral health into disease management; vendors may have additional experience in this area. It is important to note that while a carve-in arrangement is the most obvious way to focus more efforts as benefits are administered through a single vendor for medical and dental, so they can internally coordinate care, though other arrangements can also foster such connections. For example, Connecticut's health and dental ASO vendors focus on coordinating care between dentists and primary care physicians especially for those with particular medical conditions.²⁸
- HCA could also choose to dedicate internal funding and resources to tackle these value-added activities if it is believed that would be a better solution.

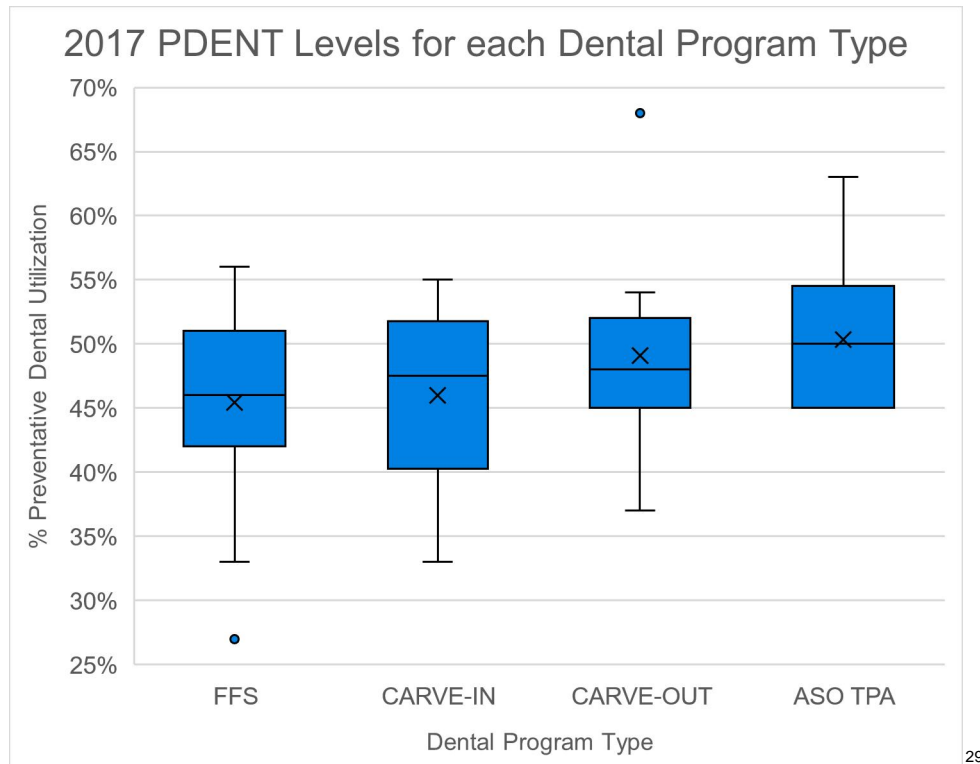
Analysis of Medicaid Dental Statistics by Program Type

In this section, we review publicly available statistics on Medicaid dental programs to assess whether any particular dental program arrangement meaningfully outperforms other program types and whether different types of programs correlate with other state-specific characteristics or measures. We present observations based on publicly available data; we are not advocating for any particular Medicaid dental delivery system. It is also important to note that a correlation between dental utilization and another statistic does not imply a causative relationship between the two variables. The success of any Medicaid dental program is based on a myriad of interrelated factors and state-specific characteristics.

²⁸ Notes from HCA interview with Connecticut Medicaid program managers (Kate McEvoy et al.) October 3, 2019.

CHILD UTILIZATION RATES BY DENTAL PROGRAM TYPE

We used the categorization of dental program type by state in as identified in Figure 1, except that the two “Other” states were grouped into the Carve-In category for this analysis. Child dental utilization (using 2017 CMS PDENT scores) by program type is as follows:



BOX PLOT TIPS: HOW TO READ BOX PLOTS

The box plot can be read as follows:

Top line – This is the upper bound, or highest value, in the sample data (excluding outliers).

Top of Box – This is the upper quartile, meaning that 75% of data points are below this level.

Middle of Box – This is the median, meaning that 50% of data points are below this level.

“x” – This is the mean of the data.

Bottom of Box – This is the bottom quartile, meaning that 25% of data points are below this level.

Bottom Line – This is the lowest value in the sample data (excluding outliers).

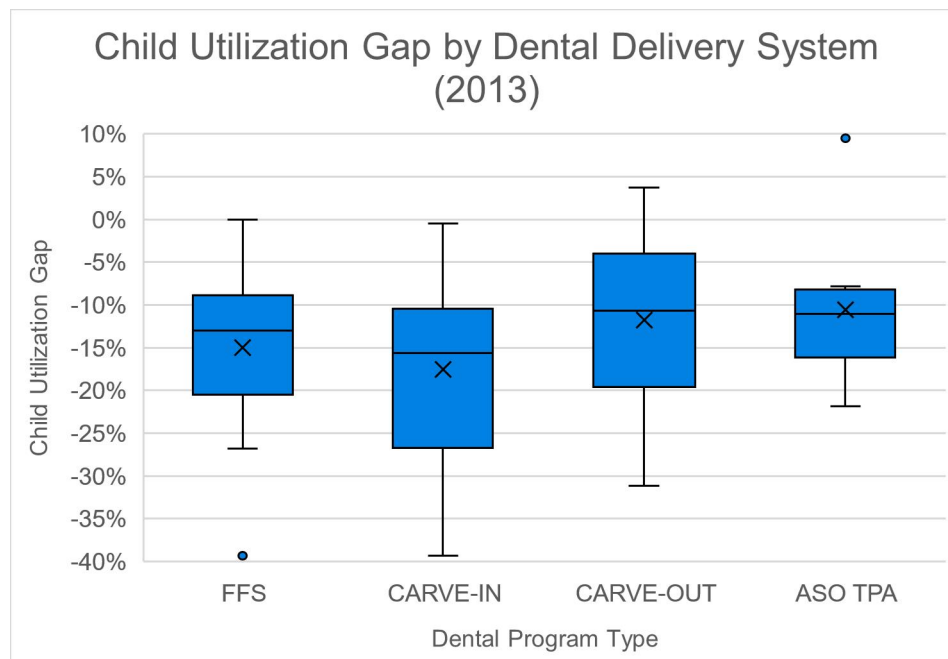
Dots – These are outliers.

The above figure shows the median PDENT statistics are between 45% and 50% for all program types, and that FFS and carve-in programs may have wider variation in preventative dental utilization outcomes for children. However, there are 19 and 20 FFS and carve-in dental program types, respectively, while there are only 12 carve-out programs

²⁹ Percentage of Eligibles Who Received Preventive Dental Services: Ages 1-20. Center for Medicare & Medicaid Services. <https://www.medicaid.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/dental-services/index.html>. Note that eligibility is based on individuals enrolled in Medicaid or CHIP programs for at least 90 continuous days. Note that the above graphic does not include utilization data for the state of Idaho. The above graphic also considers Oregon and Vermont as carve-in programs.

and nine ASO/TPA programs (note some states are categorized as having multiple dental program types). As a result, the larger variation may be due to the additional data points. While it appears that the ASO/TPA may result in the best child dental utilization numbers overall, we are hesitant to draw any major conclusions based on this one statistic due to its limitations. In particular, PDENT indicates absolute levels of child Medicaid dental utilization, which can depend on state specific characteristics such as geography (i.e. more rural versus more urban states), number of licensed and participating dental providers, and demographics of the Medicaid population. As a result, this statistic may not adequately isolate for the effectiveness of a particular Medicaid dental program type.

To minimize disparities between states, we also consider the utilization **gap** between Medicaid and commercially insured populations. This helps to better isolate the effectiveness of a state's Medicaid program as it compares each state to its own commercially insured population benchmark. Using the 2013 American Dental Association utilization data, it does not appear that the type of Medicaid dental program is correlated with the utilization gap between Medicaid and commercial populations. This suggests that any type Medicaid dental program is capable of generating utilization closer to commercial levels. In the figure below, the "utilization gap" measurement represents Medicaid child utilization levels for 2013 minus commercial child utilization levels for 2013. Lower percentages (i.e. larger negative numbers) indicate the state's Medicaid program lags further behind its commercial counterpart.³⁰



This graphic does have limitations. The utilization data presented is from 2013 while the dental program type categorizations are based on the most recent information available; certain states may have changed their dental program type over the last few years. That being said, we observe Medicaid dental utilization within 10% of commercial levels for all program types shown above, indicating that the set-up of the Medicaid dental program is not necessarily a factor that limits a state's ability to achieve small gaps in utilization between Medicaid and commercially insured populations.

LEVEL OF ADULT DENTAL BENEFITS BY DENTAL PROGRAM TYPE

While all states are required to include child dental services under Medicaid, there are no minimum coverage requirements for adult dental procedures. Covered dental procedures for adults vary widely by state, from minimal

³⁰ Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrow, Remains Large for Adults. Vujicic, M and Nasseh, K. American Dental Association Health Policy Institute Research Brief, December 2015. The above graphic also considers Oregon and Vermont as carve-in programs.

emergency coverage to comprehensive coverage of most dental services. Most states have opted to provide at least emergency dental services for adults.³¹

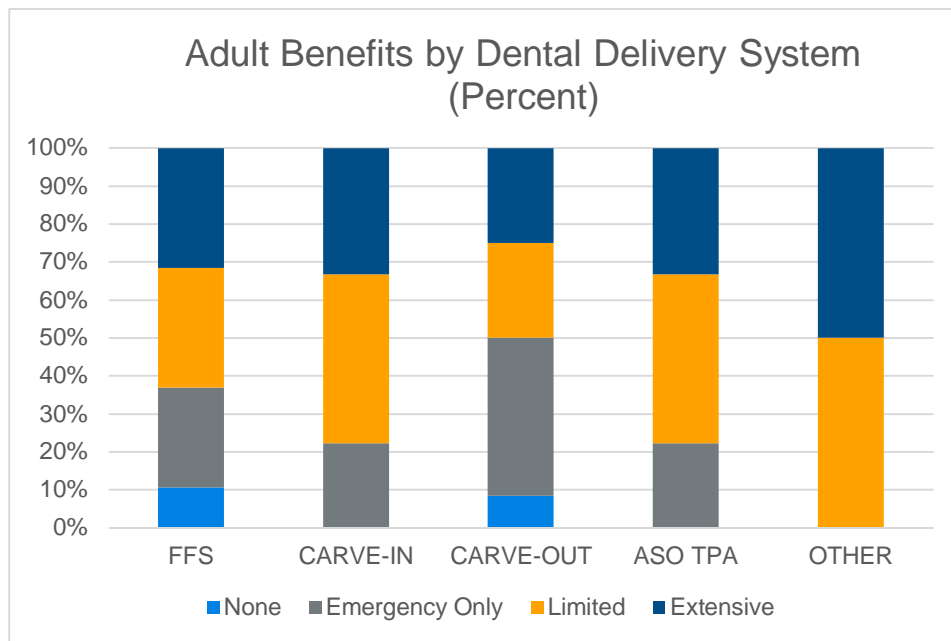
The level of adult benefit is defined as:

- **Extensive** means more than 100 dental procedures covered with an annual benefit limit over \$1,000,
- **Limited** means fewer than 100 dental procedures covered with an annual benefit limit less than \$1,000 and
- **Emergency Only** coverage provides pain relief under emergency circumstances only

In addition to varying coverage by state, the level of adult Medicaid dental benefits can fluctuate over time within a given state. Existing adult dental benefits may be reduced or eliminated due to budget concerns, and conversely, benefits may be added or reinstated when the state budget allows. The adult dental benefit offering can heavily affect adult dental utilization and fluctuating benefit levels often cause parallel movements in utilization. According to a Center for Health Care Strategies fact sheet:

“In response to fiscal challenges many states reduced or eliminated Medicaid dental coverage over the past decade, with a concurrent 10 percent decline in oral health care utilization among low-income adults.”^{32, 33}

We cross-referenced the level of adult Medicaid dental benefit in each state with the Medicaid dental program type in that state to see if states with higher adult dental benefits were more likely to choose a particular type of Medicaid dental program. The figure below illustrates the breakdown of adult benefits offered within each dental type.



Categorizations of dental program types are consistent with what is listed in Figure 1.³⁴ It appears that there is no significant correlation between adult benefit levels and the type of program chosen; states with extensive adult benefits administer their Medicaid dental benefit using the full spectrum of approaches.

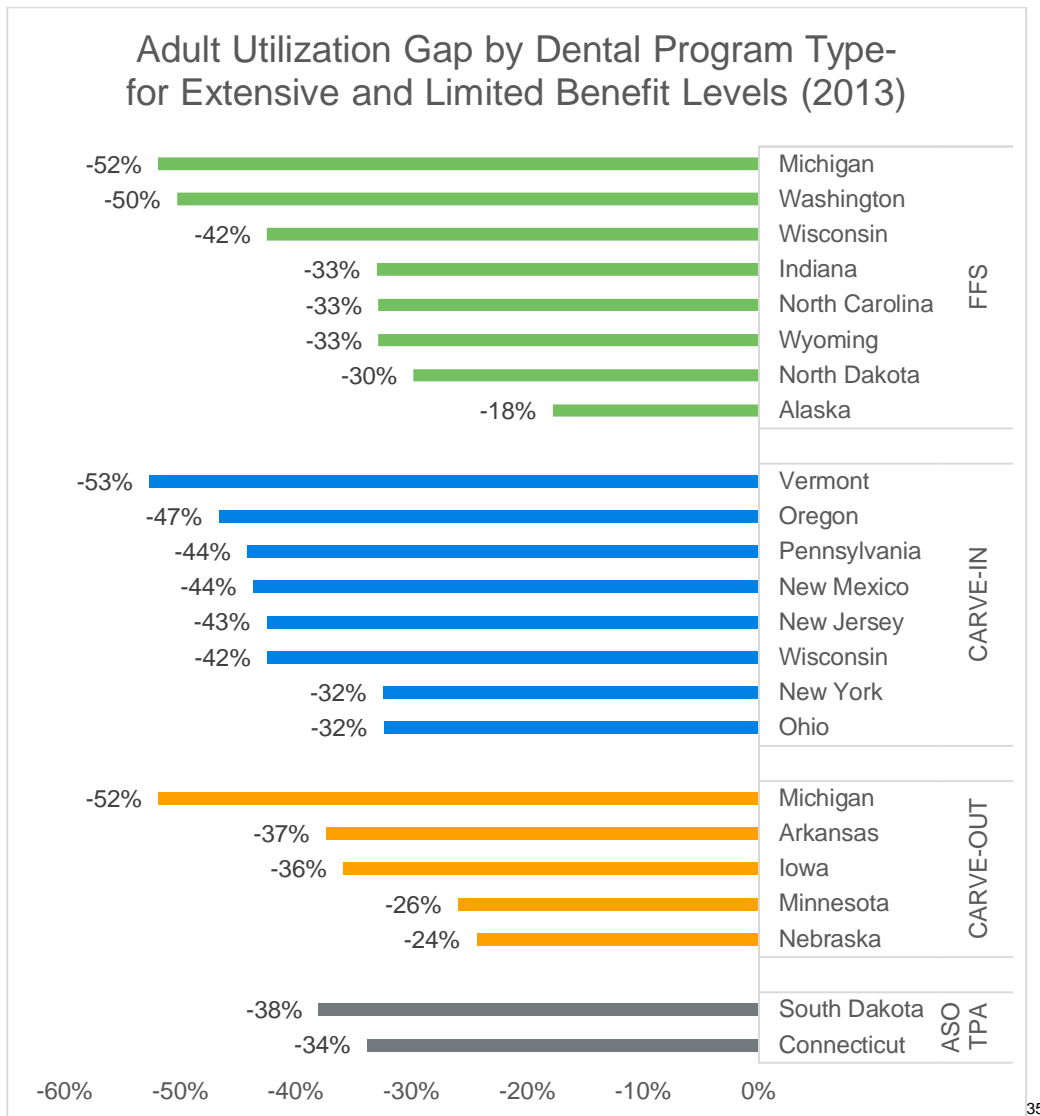
For states that have at least limited Medicaid dental benefits for adults, we reviewed the utilization gap between adult Medicaid beneficiaries and commercially insured adults by dental program type. A lower utilization gap (i.e. a larger negative number) indicates that adult Medicaid programs lag behind their Commercial counterpart.

³¹ <https://www.medicaid.gov/medicaid/benefits/dental/index.html>

³² Medicaid Adult Dental Benefits: An Overview. Center for Health Care Strategies, Inc. https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_011618.pdf. Accessed September 24, 2019.

³³ Dental Care Utilization Declined for Adults, Increased for Children During the Past Decade in the United States. Nasseh, K, Vujcic, M, and Wall, T. American Dental Association Health Policy Institute Research Brief, February 2013

³⁴ Medicaid Adult Dental Benefits: An Overview. Center for Health Care Strategies, Inc. https://www.chcs.org/media/Adult-Oral-Health-Fact-Sheet_011618.pdf. Accessed September 24, 2019.



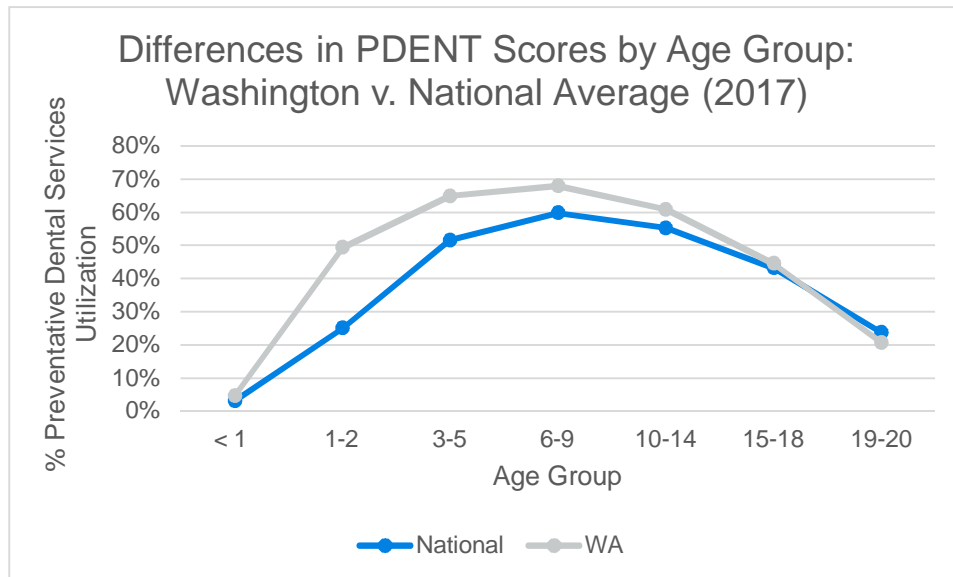
The graphic indicates wide variation in utilization gaps within each type of dental program, and we suspect that there are many moving factors in addition to the program set-up that produce the utilization results. Again, adult utilization data is from 2013 while the program categorization is based on current-day, due to lack of more current adult utilization information. Also, as previously noted, Washington had suspended its adult dental benefit during this time period; however, the state's adult utilization levels for 2014 and beyond are still significantly lower than commercial utilization. Despite the limitations of this dataset, the range of results indicates that no one program type stands out as having a clear advantage in pushing adult Medicaid utilization closer to commercial levels.

PROVIDER REIMBURSEMENT RATES BY DENTAL PROGRAM TYPE

Low Medicaid dental provider reimbursement rates are often cited as a primary driving force for dentists' reluctance to participate in state Medicaid programs. Washington's experience provides evidence of this; the impact of the ABCD program helps illustrate how reimbursement rates impact utilization. The ABCD program targets children from birth to age five; due to its success, these children receive dental services much more frequently than the national average. However, as children age out of the program – and as providers no longer receive ABCD enhanced reimbursement

³⁵ Gap in Dental Care Utilization Between Medicaid and Privately Insured Children Narrow, Remains Large for Adults. Vujicic, M and Nasseh, K. American Dental Association Health Policy Institute Research Brief, December 2015. While the figure only contains states with extensive or limited levels of adult dental benefits, it does not include all states. Certain states that offer extensive or limited benefits were excluded due to a lack of available data. The above graphic also considers Oregon and Vermont as carve-in programs.

or targeted outreach – there is a convergence to national average utilization rates. Child utilization compared to the national average is demonstrated in the table below. Washington also uses separate Medicaid provider fee schedules for adults and children, with the adult fees lower than child fees compared to commercial reimbursement levels. As stated previously, Washington’s Medicaid adult FFS reimbursement rate was about 32% of commercial fees; this was third lowest among states with available data (16 total states).³⁶



37

Other examples where targeted rate increases led to a positive utilization impact are in Connecticut and Texas. In 2008, Connecticut dental reimbursement rates were increased to the 70th percentile of commercial dental insurance rates, resulting in a significant increase in provider participation. In 2007, the Texas Medicaid program increased dental reimbursement rates by more than 50 percent. By 2010, dental care utilization among Medicaid enrolled children in Texas increased so much that it actually exceeded the rate of those with commercial insurance.³⁸

In a study from the National Academy for State Policy, the authors researched six states that took dramatic steps toward improving access to dental care in Medicaid in the late 1990s and early 2000s. It was found that in the six states examined, provider participation increased by at least one-third and sometimes more than doubled following reimbursement rate increases. The authors also emphasized that:

“Rate increases are necessary – but not sufficient on their own – to improve access to dental care. Easing administrative processes and involving state dental societies and individual dentists as active partners in program improvement are also critical. Administrative streamlining and working closely with dentists can help maximize the benefit of smaller rate increases, and mitigate potential damage when state budgets contract.”³⁹

³⁶ Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016. Gupta, N. et al. American Dental Association Health Policy Institute Research Brief, April 2017.

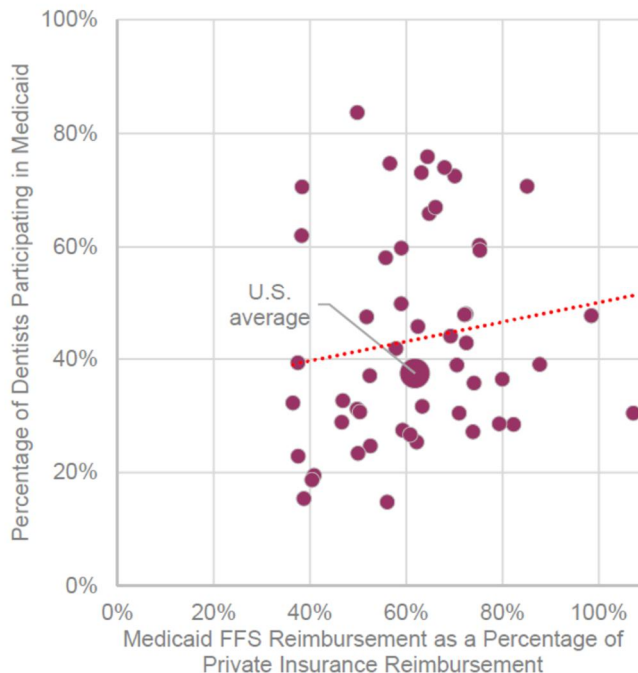
³⁷ Percentage of Eligibles Who Received Preventive Dental Services: Ages 1-20. Center for Medicare & Medicaid Services. <https://www.medicare.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/dental-services/index.html>.

³⁸ Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016. Gupta, N. et al. American Dental Association Health Policy Institute Research Brief, April 2017.

³⁹ The Effects of Medicaid Reimbursement Rates on Access to Dental Care. Borchgrevink, A. et al. National Academy for State Health Policy. March 2008.

The chart below, taken from an American Dental Association study using 2016 data, also shows a positive correlation between reimbursement rates and Medicaid participation.⁴⁰

REIMBURSEMENT AND PROVIDER PARTICIPATION IN MEDICAID FOR DENTISTS IN EVERY STATE



Data analysis and graphic design courtesy of the ADA Health Policy Institute

In a working paper from the National Bureau of Economic Research it was also found that there is a modest but statistically significant positive relationship between Medicaid payment rates and dental care utilization/access to dental care. Since the magnitude of this effect is small, increasing Medicaid payments would increase access to care, but the incremental cost of the additional visit is high.⁴¹ This study highlights the concept that improving utilization via increased provider payments comes with the price tag associated with those higher provider fees.

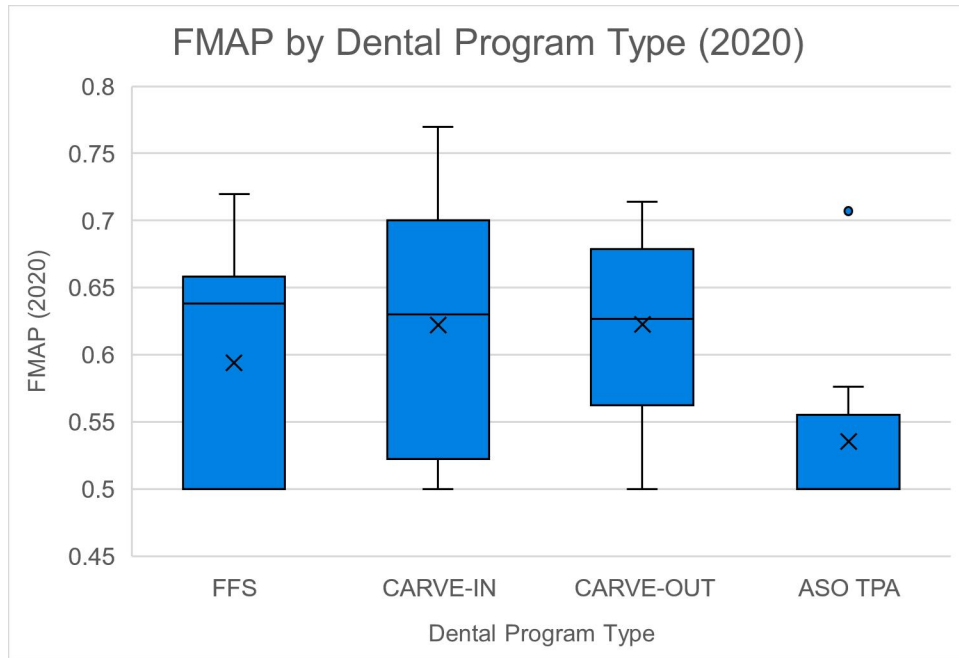
STATISTICS RELATED TO FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP)

The Federal Medical Assistance Percentage (FMAP) represents the federal government's financial share of Medicaid benefits, varying by state with a minimum rate of 50%. It is computed based on the average per capita income for a given state compared to the national average. FMAP can be used as a broad proxy for the relative wealth level of a state; a lower FMAP indicates lower federal funding based on higher state wealth.

We analyzed the relationship between Medicaid dental program type and 2020 FMAP to see if relative state wealth was correlated with the type of Medicaid dental program pursued by the state. In the figure below, you can see that the median FMAP is similar for FFS, Carve-in, and Carve-out programs and that these program types are used in states with a wide variety of FMAP levels. It is interesting that ASO/TPA programs seem to be most prevalent among low FMAP (i.e. high relative wealth) states, although many low FMAP states also use FFS, Carve-in, and Carve-out approaches.

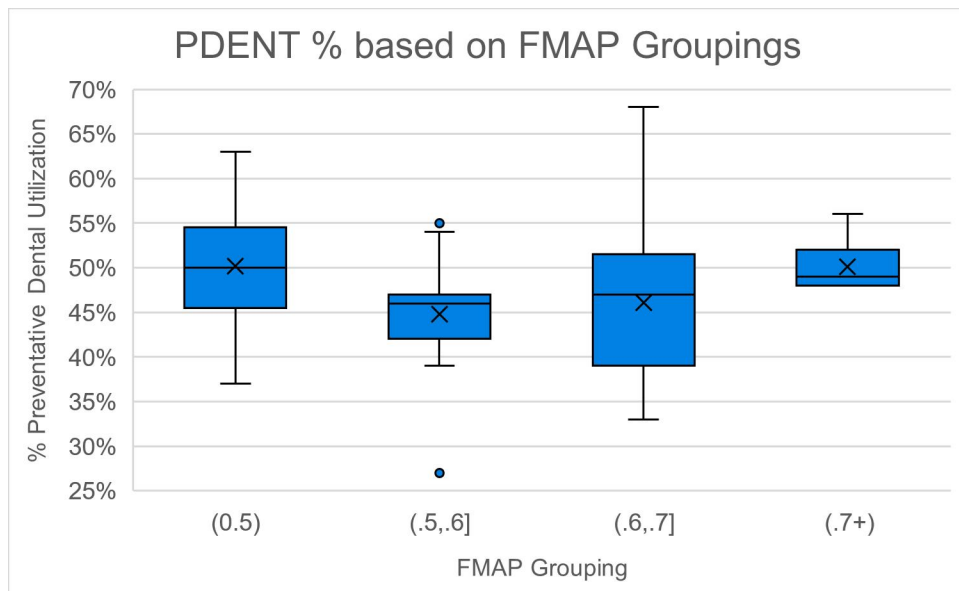
⁴⁰ Medicaid Fee-for-Service (FFS) Reimbursement and Provider Participation for Dentists and Physicians in Every State. American Dental Association Health Policy Institute. 2016.

⁴¹ THE EFFECT OF MEDICAID PAYMENT RATES ON ACCESS TO DENTAL CARE AMONG CHILDREN. Buchmueller, T. et al. National Bureau of Economic Research. https://www.nber.org/papers/w19218.pdf?new_window=1. Accessed September 27, 2019.



42

We also charted FMAP against child preventive dental utilization statistics for Medicaid children. FMAP percentages appear to have some degree of correlation with dental utilization. In particular, the states with the lowest FMAP percentage of 50%, as well as the states with the highest FMAP percentages, appear to be most associated with higher preventive dental utilization among Medicaid children.



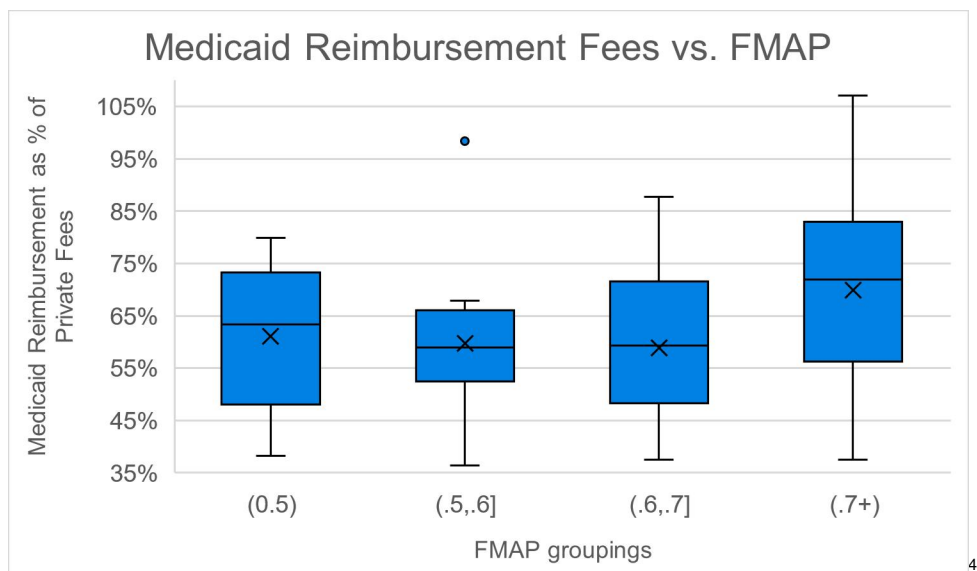
43

We also investigated the correlation between Medicaid provider reimbursement and state FMAP. Reimbursement levels appear to be slightly greater in high FMAP states. This suggests states with lower per capita income have a higher reimbursement rate on average. This also correlates with the results in the prior chart which indicate relatively

⁴² <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁴³ Percentage of Eligibles Who Received Preventive Dental Services: Ages 1-20. Center for Medicare & Medicaid Services. <https://www.medicare.gov/state-overviews/scorecard/state-health-system-performance/prevention-and-treatment/dental-services/index.html>.

higher child utilization in high FMAP states, indicating another potential link between reimbursement levels and access.



Other Key Success Factors and Innovative Approaches

The success of a Medicaid dental program is not directly dependent on the type of program; no one particular type of dental program will necessarily result in increased access for Medicaid beneficiaries. In this section we review key elements of successful programs – i.e., programs that have achieved increases in dental utilization – and provide state-specific examples. We also discuss innovative or emerging initiatives in some states to further enhance their Medicaid dental programs.

Hallmarks of successful Medicaid dental programs include the following elements.

PROVIDER-FOCUSED INITIATIVES

Finding ways to engage providers, improve their experience in the Medicaid dental program, and align their incentives with other program stakeholders can incent higher levels of provider participation and improve access to care.

Improving the provider experience

In 2011, CMS published an eight-state review summarizing best practices among specific states that had successfully increased Medicaid dental utilization. One noted element of the programs was a simplification of administrative processes for providers; multiple states moved from multiple claim forms to a single universal one, and Virginia, in particular, significantly reduced the prior authorizations necessary for dental services.⁴⁵ According to the provider survey conducted by WA HCA earlier this year, aside from reimbursement increases, providers ranked simplifying the prior authorization process and support with missed appointments as highly important potential improvements.

Leveraging non-traditional dental providers

The CMS eight-state review also noted that to improve access to dental care, states such as North Carolina, Rhode Island, and Texas have trained and certified primary care physicians to perform dental risk assessments, furnish fluoride varnish applications, and make appropriate referrals to a dentist.⁴⁶ The ABCD program uses physicians in

⁴⁴ Medicaid Fee-For-Service Reimbursement Rates for Child and Adult Dental Care Services for all States, 2016. Gupta, N. et al. American Dental Association Health Policy Institute Research Brief, April 2017.

⁴⁵ Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

⁴⁶Ibid.

this manner for children aged five or under. Some states are also making strides toward increasing access via use of lower level dental providers for particular types of care; this topic is covered more fully in a later section of this paper.

Enabling the provider enrollment process

In Alabama, the state visited dentists who accepted private insurance but did not participate in Medicaid and would assist them in filling out application forms on-site.⁴⁷

BENEFICIARY-FOCUSED INITIATIVES

Another critical success element is improving the knowledge base of Medicaid dental beneficiaries and helping them overcome barriers to accessing care.

Education and outreach

Adults enrolled in Medicaid are often not aware of whether or not adult dental benefits are available under their state's Medicaid program. In contrast, parents are very aware that Medicaid programs provide dental benefits for children.⁴⁸ Studies have shown that children whose mothers have a regular source of dental care have greater dental utilization.⁴⁹ The CMS eight-state study highlighted Nebraska's beneficiary outreach effort, in which public health nurses contracted with Medicaid to contact new enrollees to inform families of benefits and provide education on the importance of utilizing those benefits. Louisiana is currently conducting an RFP for a Medicaid Dental Benefit Manager, with one of the key outcomes being promotion of dental education and enrollee responsibility.⁵⁰ Nevada's Medicaid dental administrator partners with the local community via organizations such as the Salvation Army and the Boys and Girls Club, and attends community health fairs to educate and assist Medicaid recipients.⁵¹ In New York, the MySmileBuddy iPad-based interactive program helps parents of young children in Manhattan by providing early childhood caries education and developing action towards its prevention. Children in need of care were connected to dental residents, and preliminary data from that program indicates improvements in oral health.⁵² WA's ABCD program focuses on such efforts for young children; it does not appear that the state has targeted outreach and education programs for adults.

Establishing a dental home

Along with education and outreach, establishment of a dental home at an early age can help improve oral health outcomes. For example, in 2008, Texas launched its First Dental Home program in which dentists received enhanced reimbursement for a defined set of preventative services for young children.⁵³ HCA talked with Connecticut's Medicaid program leaders about their program's successes; during the interview the Connecticut team indicated that an emphasis on dental homes particularly for young beneficiaries has led to a reduction in the need for restorative dental care for teenagers and young adults. In addition, Connecticut's dental homes offer extended operating hours providing a less expensive and more clinically appropriate alternative to emergency room usage for dental issues, which has decreased over time.⁵⁴ Washington's ABCD program is also a good example of the dental home concept focused on young children.

Transportation

Despite the fact that Medicaid includes a transportation benefit, beneficiaries may lack convenient or consistent transportation to enable them to get to dental appointments. A recent study published in the Journal of Dental Research using Iowa Medicaid dental data found that transportation concerns represent a substantial barrier to dental care. While distance to a provider was not found to be a major indicator of dental utilization, other transportation

⁴⁷ Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

⁴⁸ Key Differences in Dental Care Seeking Behavior between Medicaid and Non-Medicaid Adults and Children. Yarbrough, C, Nasseh, K, and Vujicic, M. American Dental Association Health Policy Institute Research Brief, September 2014.

⁴⁹ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4821415/>

⁵⁰ http://dh.la.gov/assets/docs/BayouHealth/Dental/DBPM_RFP_3000013043_Final_06.06.19.pdf, accessed 9/6/2019.

⁵¹ <https://www.libertydentalplan.com/About-LIBERTY/Company-Facts/LIBERTY-s-Community-Empowerment/Washoe-County-Community-Outreach.aspx> Accessed 10/6/2019.

⁵² <https://downloads.cms.gov/files/cmml/hcia2-yr3evalrpt.pdf>

⁵³ <https://www.medicaid.gov/medicaid/benefits/downloads/keep-kids-smiling.pdf>

⁵⁴ Notes from HCA interview with Connecticut Medicaid program managers (Kate McEvoy et al.) October 3, 2019.

issues such as relying on public transportation or walking to appointments were impediments to accessing care, and concern about the cost of transportation had the strongest association with dental utilization.⁵⁵ Programs that improve the convenience, simplicity, and timeliness of transportation to dental appointments could enable higher utilization of dental services.

Community-based care

Another way to combat the difficulty some Medicaid beneficiaries face in traveling to dental appointments is to provide care in places where those beneficiaries live, work, go to school, or access other services. Using community-based providers can improve access to care. For example, North Carolina has trained Early Head Start staff to perform basic oral health activities for young children. California's Virtual Dental Home model uses hygienists or other professionals in community settings and relies on teledentistry to connect with dentists as needed or refers patients for a live dental visit.⁵⁶ A pilot program in New Hampshire is experimenting with co-delivery of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and oral health services in the same setting. A certified public health hygienist and dental assistant hold office hours at designated WIC locations providing preventive dental services by appointment or on a walk-in basis, and the WIC and dental personnel can collaborate to deliver consistent messaging regarding nutrition and oral care.⁵⁷

Partnerships with Dental Schools

Several dental schools in states such as Alabama, Nebraska, and North Carolina operate dental clinics in underserved rural areas, staffed by dental students, to improve access to care in those areas as well as promote outreach and education. CMS' eight state review also indicated that five of the reviewed states (Alabama, Maryland, Nebraska, North Carolina, and Texas) have loan repayment programs for dentists that generally require a student to serve in a rural area for a period of time in order to receive an annual payment for their dental school loans.⁵⁸ In Utah, blind or disabled Medicaid recipients may receive dental care at the University of Utah School of Dentistry.⁵⁹ WA also recognizes the importance of partnerships with state dental programs for the benefit of Medicaid dental beneficiaries via special reimbursement to the University of Washington School of Dentistry based on their disproportionate share of Medicaid beneficiaries as well as additional reimbursement for services provided under the Dental Education in the Care of Persons with Disabilities (DECOD) program.

EMERGING AND INNOVATIVE MEDICAID DENTAL PROGRAM PRACTICES

Some states have started to experiment with new approaches to improve their Medicaid dental program; here we review a few of these trends.

Use of dental therapists

Dental therapists, mid-level dental providers similar to physicians' assistants, can help to fill access gaps in rural areas or in areas where an insufficient number of dentists accept Medicaid patients. These providers typically receive more training than hygienists but not as much as dentists; they can generally handle procedures such as fillings, temporary crowns, and extractions.⁶⁰ Several states have authorized dental therapists to practice in some capacity. The map below, recreated from a Pew Charitable Trust study updated as of August 2019, details state progress in allowing dental therapists to practice. Other states are actively exploring the concept and the source document is periodically updated to reflect new information.⁶¹

⁵⁵ McKernan, S.C. et al. Transportation Barriers and Use of Dental Services among Medicaid-Insured Adults. *Journal of Dental Research* Volume 3 Issue 1, January 2018.

⁵⁶ <https://dental.pacific.edu/departments-and-groups/pacific-center-for-special-care/innovations-center/virtual-dental-home-system-of-care/about-the-virtual-dental-home>. Accessed 9/29/2019.

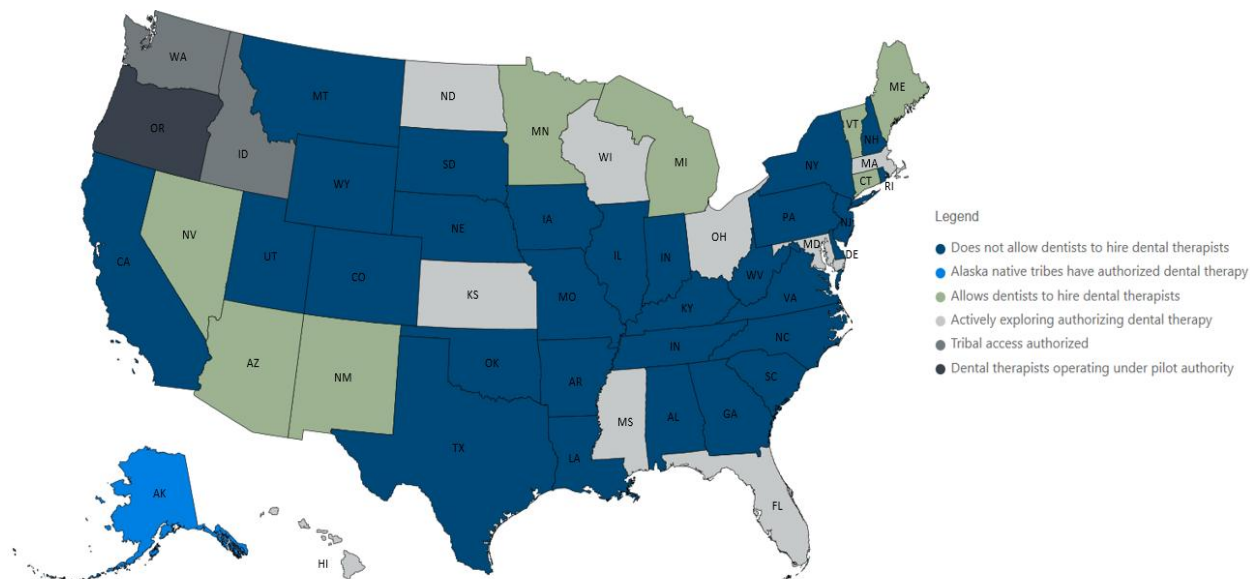
⁵⁷ Insights and Key Considerations for Implementing Value-Based Payment in Children's Oral Health: Perspectives from Participating States. Webinar, 8/27/2019

⁵⁸ Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

⁵⁹ <https://medicaid.utah.gov/medicaid-dental-benefits>, accessed 9/3/2019.

⁶⁰ Villeneuve, M. Backers of Rural Dental Care Find Something to Smile About. *The Associated Press*. August 18, 2019.

⁶¹ Koppelman, J et al. States Expand the Use of Dental Therapy. *The Pew Charitable Trusts*. September 28, 2016 with updates through August 7, 2019.



Proponents of the use of dental therapists highlight the potential improvements in access to care for dental patients living in underserved areas, and overall better access to preventive care by allowing dentists to focus on more complex procedures. However, some dentists argue that therapists lack the education or experience to perform such procedures and could put patient safety at risk. The ADA states that it is “in the best interests of the public that only dentists diagnose dental disease and perform surgical and irreversible procedures”.⁶² In addition, training programs for dental therapists vary widely and may not be accredited. Some states such as Minnesota require therapists to practice in dental offices, while other states such as Vermont and Maine, do not require a dentist to be present. Master degree programs generally satisfy opponents’ safety concerns but can be expensive for students, while some advocates argue that hygienist-level training is sufficient.⁶³

Teledentistry

Some states are actively using teledentistry to improve access in remote or underserved areas. Teledentistry can involve real-time interactions with a remote dental provider, or asynchronous activities such as sending images, records, or other data to a provider who will review and recommend treatment. California’s 2019 ASO Outreach Plan promotes teledentistry and the Virtual Dental Home model of dental care.⁶⁴ In the Virtual Dental Home, dental practitioners provide preventative and restorative care in community settings, and offsite dentists receive info electronically and create a treatment plan.⁶⁵ As of 2018 the American Dental Association provides two procedure codes for teledentistry, allowing programs to capture and monitor the number and types of services delivered via this modality. States that explicitly include teledentistry services in their Medicaid programs include not only California but also Arizona, Hawaii, Minnesota, Missouri, Montana, and New York.

Value-based payments (VBP)

An article in the New England Journal of Medicine Catalyst defines value-based care as:

“a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes... Value-based care differs from a fee-for-service or capitated approach, in which providers are

⁶² More States Could Soon Broaden Authorized “Dental Therapist” Procedures. Planet DDS Blog. February 21, 2017.

⁶³ Koppelman, J et al. States Expand the Use of Dental Therapy. The Pew Charitable Trusts. September 28, 2016 with updates through August 7, 2019.

⁶⁴ 2019 Medi-Cal Dental Member and Provider Outreach Plan. Delta Dental in Partnership with the California Department of Health Care Services. https://www.dhcs.ca.gov/services/Documents/MDS/Approved-ASO_OUTREACH_PLAN_1-4-19.pdf. Accessed October 1, 2019.

⁶⁵ Improving Access to Oral Health Care for Adults in Medicaid: Key Themes from a Policy Roundtable. Paradise, J. The Henry J. Kaiser Family Foundation. August 2016. <https://www.kff.org/report-section/improving-access-to-oral-health-care-for-adults-in-medicaid-key-themes-from-a-policy-roundtable-report/>. Accessed October 1, 2019.

*paid based on the amount of healthcare services they deliver. The 'value' in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.*⁶⁶

The use of VBP in dental programs is emerging, and information regarding their effectiveness on dental cost and utilization is still developing; however, some states have started to explore the concept. For example, under California's Dental Transformation Initiative, incentive payments are paid to dental offices that meet a predetermined increase in preventative services for Medicaid beneficiaries.⁶⁷ Ohio's Medicaid program uses an episode of care payment model for tooth extractions, rewarding providers based on cost and quality outcomes.⁶⁸ Other states have pursued innovations via the Medicaid Innovation Accelerator Program Value-Based Payment and Financial Simulations Technical Support program, which offers individualized technical support for states interested in designing, developing, or implementing VBP approaches.⁶⁹ In a webinar by program participants, survey results were presented that indicated that while only 15% of states are working on designing Medicaid dental VBP, another 35% are not yet considering but interested in the concept.⁷⁰ Representatives from Washington DC, Michigan, and New Hampshire talked about state specific initiatives involving Medicaid dental VBP. Overarching themes included:

- (1) the VBP implementation process is iterative, with consistent evaluation and re-evaluation;
- (2) data infrastructure is critical to ensure capture of the appropriate benchmarks and measurement against those standards; and
- (3) engagement and alignment of policyholders, payers, clinicians, and other stakeholders is vital to success.⁷¹

Additionally, it takes time to implement a successful VBP program. The initial iteration of the program can be challenging, as it takes time for data to develop; once available, the data can be used to create a comprehensive plan that will best focus provider efforts on the most important outcome measures.

Capitation payment withholds/incentives

In the carve-in or carve-out scenarios, VBP methods may be difficult to implement, given that an MCO or DMCO is managing the payments to the providers. In these situations, payment to a capitated plan may be subject to performance tied to specific quality measures. For example, Florida has a carve-out arrangement with DMCOs where a portion of the capitation rate is withheld. The return of the withhold back to DMCOs is tied to meeting certain CMS PDENT (Percentage of Eligibles Who Received Preventative Dental Services: Ages 1-20) or TDENT (Percentage of Eligibles who Received Treatment Dental Services: Ages 1-20) measures. Tying the capitation payment to these types of measures will financially incentivize the MCO or DMCO with improving the dental care for the Medicaid population.

Dental Champion

The CMS eight-state review found that having a high-profile dental "champion" in the state who is willing to take on a public leadership role in prioritizing and promoting Medicaid oral health initiatives can be a critical success factor. This may be the state Medicaid or Dental Director, or, as in states such as Maryland and Rhode Island, a representative from the Governor's office or State legislature.⁷² A person dedicated to oral health programs can ensure that these initiatives are given the proper priority and publicity; in addition, the dental champion can work with stakeholders to solicit feedback, align incentives, and ensure program buy-in. Connecticut also employs a Dental Director who,

⁶⁶ <https://catalyst.nejm.org/what-is-value-based-healthcare/>. Accessed 10/30/2019.

⁶⁷ <https://www.dhcs.ca.gov/Documents/MDSD/Domain%201%20docs/DI-Domain-1-Fact-Sheet-61219.pdf>

⁶⁸ Clary, A. et al. State Strategies to Incorporate Oral Health into Medicaid Payment and Delivery Models for Chronic or High-Cost Medical Conditions. National Academy for State Health Policy, July 2018.

⁶⁹ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-functional-areas/value-based-payment/index.html>. Accessed 9/30/2019.

⁷⁰ Insights and Key Considerations for Implementing Value-Based Payment in Children's Oral Health: Perspectives from Participating States. Webinar, 8/27/2019

⁷¹

Insights and Key Considerations for Implementing Value-Based Payment in Children's Oral Health: Perspectives from Participating States. Webinar, 8/27/2019

⁷² Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

among other duties, partners with the state dental association and local providers.⁷³ Washington employs a part-time dental director who can play such a role.

Connecting Oral and Medical Health

A full analysis of the correlations between oral and overall physical health is beyond the scope of this paper, but there is a large body of clinical research suggesting connections between oral health and the development or maintenance of chronic diseases such as diabetes, heart disease, strokes, and respiratory disease, as well as pre-term or low-birth-weight babies. Washington's Oral Health Connections Pilot Program, aimed to test the effect of enhanced oral health services on the overall health of pregnant women and of adults with diabetes, is an example of such an innovation which has been lauded in industry articles.⁷⁴ Reviewing the experience of patients who receive coordinated medical and dental care in FQHCs can provide valuable lessons for broader implementation of integrated medical/dental care protocols.⁷⁵

Carve-in dental programs in which the dental and medical benefit are provided under the same MCO contract may provide further opportunities for care integration. In various MCO responses to surveys solicited by WA HCA earlier this year, the importance of integration of medical and dental care was highlighted. Key elements of an integrated program include the ability to reduce emergency room visits and admissions related to dental diagnoses, early diagnosis of medical diseases by dentists, and the potential for longer term overall cost savings due to better oral and physical population health. That being said, while carve-in programs provide a structure primed for promotion of medical/dental integration, such integration can be achieved under other program structures as well with appropriate focus and contractual elements.

Conclusion and Implications for State of Washington

ONE SIZE DOESN'T FIT ALL

The conclusion of the CMS eight-state Medicaid dental program review states that “there is no ‘one size fits all’ solution to increasing dental access for Medicaid eligible children. State variance of populations, available funding, and political will varies greatly across the nation.”⁷⁶ CMS also found that in five states which successfully improved dental utilization, collaboration among stakeholders was crucial. Partnerships with State agencies, State legislatures, State dental associations, dental/medical providers, and other parties were critical towards improving the dental program.⁷⁷ Our research yielded similar conclusions. Each state has unique needs -- special populations, geographic considerations, provider environment, political landscape, adult dental benefit composition, beneficiary characteristics, program funding levels, and more – that must be considered in improving the success of a Medicaid dental program.

Washington is a leader in Medicaid oral health initiatives in many ways. With high child dental utilization rates further strengthened by the ABCD early childhood dental program, Medicaid children in the state fare well relative to national benchmarks. Adults are fortunate to have extensive Medicaid dental benefits, and the Oral Health Connections program shows the ability of the state to consider innovative approaches to improve the oral and physical health of Medicaid beneficiaries with chronic conditions. In recognition of provider needs, enhanced fee programs are in place for specific provider groups serving a disproportionate share of Medicaid beneficiaries. That being said, some important elements of Washington's Medicaid dental program lag national indicators, including adult dental utilization, dental provider reimbursement, and dental provider participation in Medicaid. Based on our research and analysis, we believe that key areas of focus for utilization improvement under Washington's Medicaid dental program include the following:

- i Utilization for Washington's Medicaid adult population lags behind national norms, both on an absolute level and relative to Washington's commercially insured population. Dental provider fees for adults are also low on an

⁷³ Notes from HCA interview with Connecticut Medicaid program managers (Kate McEvoy et al.) October 3, 2019.

⁷⁴ Clary, A. et al. State Strategies to Incorporate Oral Health into Medicaid Payment and Delivery Models for Chronic or High-Cost Medical Conditions. National Academy for State Health Policy, July 2018.

⁷⁵ Ibid.

⁷⁶ Innovative State Practices for Improving the Provision of Medicaid Dental Services: Summary of Eight State Reports: (Alabama, Arizona, Maryland, Nebraska, North Carolina, Rhode Island, Texas, and Virginia). Centers for Medicaid and Medicare Services, January 2011.

⁷⁷ Ibid.

absolute basis compared with other states, relative to Washington child Medicaid dental fees, and relative to Washington commercial dental reimbursement levels; this could be a major driver of low provider participation in the Medicaid program and hence the low levels of adult dental utilization in the state.

- i As stated earlier, enhancements to provider reimbursement are often necessary but not sufficient steps to improve utilization of services. Implementing or enhancing programs geared toward adults including targeted outreach, beneficiary education, improved transportation assistance, improvement of access to community-based care, and other activities to reduce the barriers to obtaining dental care can also pave the way for higher utilization of services.
- i While child Medicaid utilization levels are strong, there is still a considerable gap compared with the state's commercially insured child population; programs that are designed to improve adult utilization may have a spillover effect to also further improve child utilization and bring it closer to that of Washington's commercially insured children.

MITIGATING RISKS OF ANY APPROACH

Based on our review, we believe that any Medicaid dental program construct could be a viable alternative for Washington to pursue. Any type of program can be successful in increasing utilization with the proper focus, incentive alignment, funding, and performance measurement and management. Based on what we know about Washington's current program, we provide considerations for success under each potential Medicaid dental arrangement.

FFS

The state already administers a successful FFS Medicaid dental program. Building on what already exists and focusing on the elements of the program that have been acknowledged as improvement areas would allow the state to continue to retain control over all aspects of the program and would eliminate any significant disruption to beneficiaries. Improving upon the current FFS program also keeps the number of involved stakeholders to a minimum, and reduces the need to involve vendors whose fees include a profit component; all dollars go directly to the state program. That being said, external vendors used in other dental program constructs may have expertise in various areas such as beneficiary outreach, medical/dental coordination, provider contracting, and other specialties that the state does not currently possess, which may be critical to improving utilization of dental services. Within a FFS construct the state could invest in developing such expertise in-house but that would likely require funding and resources beyond what exists today and could potentially be more efficiently done by firms with existing expertise.

ASO/TPA

An ASO/TPA arrangement would represent a minimally disruptive change to the current FFS system. It could also provide a pathway for the state to test targeted program innovations with a third-party vendor, taking an initial step toward managed care. The TPA's administrative expertise, provider network contacts, and beneficiary engagement experience could potentially improve program efficiency. Under an ASO/TPA arrangement, beneficiaries would continue to interact with just one vendor, as they do today directly with the state. As the state would retain claims risk, it will be important for the ASO contract to clearly define metrics to ensure that the ASO vendor focuses on activities that optimize utilization of services. Potentially using an "ASO plus risk sharing" model could help to align incentives in that way. A key consideration for an ASO arrangement is determining whether the TPA could provide the defined services with greater efficiency and better outcomes than the state could do by itself, and whether the state could save resources rather than duplicate resources with a TPA.

Carve-In

A carve-in arrangement would remove variance in the cost of dental benefits for the state, as the insurance risk is transferred to one or more MCOs. However, an MCO might cost more due to the risk charge associated with transferring risk to a third party; this could potentially be offset by managed care savings initiatives that the MCO takes to control cost. Similar to an ASO vendor, MCOs likely have established administrative expertise and beneficiary engagement experience which could potentially improve program efficiency. The MCO's level of dental network capabilities compared with an ASO dental administrator would depend on whether the carrier is also a dental MCO itself or has established relationships with dental MCO vendors. A key philosophical advantage to a carve-in is

the potential for the MCO to leverage synergies between medical and dental care to create a more holistic patient experience and better outcomes. Conversely, MCOs may be incented to focus improvement efforts on medical care rather than dental care, as dental makes up a very small component of an MCO's cost basis. MCOs could subcontract with a dental vendor to administer and take risk for the dental benefit, adding a layer of complexity to the arrangement and potentially reducing the ability of the state to gain clear insights into how the dental program is running.

Moving from the current FFS arrangement to an MCO carve-in may be disruptive to beneficiaries and may require some to change providers; transition assistance and metrics could be part of the MCO contract. If multiple MCOs will be serving the population, efforts to alleviate beneficiary confusion and provider administrative burden will be critical success factors. Washington currently has five MCOs serving the Medicaid population; if they were to all carve in a dental benefit, minimizing differences in dental administrative, credentialing, and other processes would be an important area of focus.

Similar to the ASO/TPA arrangement, contracts with MCOs and associated payments to those MCOs would need to clearly define dental specific performance metrics to align with state goals and ensure sufficient focus on dental benefits, which may include provider network adequacy, beneficiary outreach, transparent dental-specific financial and clinical outcomes reporting, and other items. Within the MCO contract, establishing dental services as a separate line item at an actuarially sound capitation rate can help protect funding for oral health within the broader scope of the MCO.

Carve-out

In terms of risks and opportunities for the state, a dental carve-out has many of the same characteristics as a carve-in, including transfer of insurance risk (and the cost impact of associated risk charge and potential for offsetting managed care savings), established administrative and operational expertise, and transition challenges for providers and beneficiaries that must be managed as the program is implemented. However, there are also key differences. A DMCO may possess additional advantages such as a sole focus on improving the dental program, and a direct relationship between the DMCO and the state without an MCO intermediary resulting in greater visibility into the dental benefit program. On the other hand, a standalone DMCO arrangement could make integrated medical/dental care initiatives harder to implement; if this is a key concern, vendor contracts would need to incentivize and operationalize partnerships and shared metrics between the MCOs and DMCOs operating in the state.⁷⁸ While contracting with multiple DMCOs could improve member choice, it could also lead to more administrative hassle and disparate credentialing processes for providers unless actively managed through uniform protocols. Also, a combination of multiple MCOs and multiple DMCOs could be confusing for plan members and complex for the state to manage.

⁷⁸ Ibid.

Caveats and Limitations

This Milliman report has been prepared for the specific purpose of providing WA HCA with independent research on Medicaid dental programs to support their development of a report to the legislature as required by ESHB 1109.SL Section 210 subsection 52. This information may not be appropriate, and should not be used, for any other purpose. This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of WA HCA. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work even if we permit the distribution of our work product to such third party. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. Milliman recommends recipient be aided by its own actuary or other qualified professional when reviewing the Milliman work product.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

In performing this analysis, we relied on data and other information provided by WA HCA. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Milliman does not provide legal advice and recommends that WA HCA consult with its legal advisors regarding legal matters.

The terms of Milliman's Consulting Services Agreement with WA HCA signed on December 15, 2017 apply to this report and its use.

Acknowledgment of Qualification

We, Joanne Fontana FSA MAAA, Jennifer Gerstorff FSA MAAA, and Catherine Lewis FSA MAAA, are Consulting Actuaries for Milliman. We are members of the American Academy of Actuaries and we meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.



Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

[milliman.com](https://www.milliman.com)

CONTACT

Joanne Fontana
joanne.fontana@milliman.com

Jennifer Gerstorff
jennifer.gerstorff@milliman.com

Catherine Lewis
catherine.lewis@milliman.com

Michael Saypoff
michael.saypoff@milliman.com